The New York State
Nurses Association

Benefits Fund

Summary Plan Description

July 2024

New York State Nurses Association

NYSNA
Benefits Fund

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, 2024.

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 of Material Modifications issued by the New York State Nurses Association Benefits Fund. All changes to this plan after July 1, 2024, will appear as Summary of 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, 2024, 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 co-counsel representatives are:

Cohen, Weiss & Simon LLP, 900 Third Ave., 21st FL, Suite 2100, New York, NY, 10022-4869, (212) 356-0211

Proskauer Rose LLP, Eleven Times Square, New York, NY, 10036-8299, (212) 969-3367.

The Fund actuary and 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., Anthem BlueCross BlueShield, 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 at (877) RN BENEFITS [762-3633]. You may also write to the NYSNA Benefits Fund at PO Box 12430, Albany, NY, 12212-2430 or email the Fund office at benefitsdepartment@rnbenefits.org.

Additional information regarding the Benefits Fund is available on the Fund's website at **rnbenefits.org**. The site includes the latest benefits updates, an in-depth schedule of benefits, a list of participating employers, and 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 to contribute toward their Benefits Fund coverage through payroll deduction in accordance with their collective bargaining agreement. 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, 2024. 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.

Anthem BlueCross BlueShield
One Penn Plaza
New York, NY 10119
Anthem BlueCross BlueShield administers the Fund's self-funded medical coverage benefit.

Davis Vision, Inc.
711 Troy-Schenectady Rd.
Latham, NY 12110
Davis Vision insures the Fund's vision coverage.

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

MetLife
200 Park Avenue, 5th Floor
New York, NY 10166
MetLife insures the Fund's short-term disability benefit, 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 **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: **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: **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, 2024; 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 Hospital Center Midwives	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
Canton-Potsdam Hospital	Benefit Coverage Plan B	First day of employment
Centerlight Health Services	Benefit Coverage Plan A	First day of the month after date of hire
Champlain Valley Physicians Hospital	Benefit Coverage Plan B	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
Garnet Health Medical Center Catskills	Benefit Coverage Plan A	84 days after date of hire
Gouverneur Hospital	Benefit Coverage Plan B	First day of employment
Gracie Square Hospital	Benefit Coverage Plan A	First day of the month 60 days after date of hire
HealthAlliance Hospital	Benefit Coverage Plan B	First day of the month 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	First day of the month 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 employment
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 Morningside	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 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	First day of the month after date of hire
New York Presbyterian Hospital	Benefit Coverage Plan A	First day of the month after date of hire
One Brooklyn Health	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
Rutland Nursing Home	Benefit Coverage Plan A	First day of the month 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
South Shore University Hospital	Benefit Coverage Plan A	60 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 A	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

Association Trustees

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

Nancy Hagans, RN
NYSNA President
Maimonides Medical Center
Brooklyn, NY

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

Patricia Kane, RN
Executive Director
New York State Nurses Association
New York, NY

Tracey Kavanagh, RN
Flushing Hospital Medical Center
Flushing, NY

Aretha Morgan, RN
New York Presbyterian Hospital
New York, NY

Allyson Selby, RN
New York-Presbyterian Brooklyn
Methodist Hospital
Brooklyn, NY

Alternate:

Dennis Zgoda, Contract Coordinator
New York State Nurses Association
New York, NY

Employer Trustees

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

Jenna Hayes
Vice President
League of Voluntary Hospitals and Homes of NY
New York, NY

Marc Kramer
President
League of Voluntary Hospitals and Homes of NY
New York, NY

Jason Limson
Vice President, Labor & Employee Relations
Northwell Health
Lake Success, NY

Barbara Logan
Linn & Logan Consulting, Inc.
Brooklyn, NY

Guy Mennonna
Sr. Vice President Human Resources
Brooklyn Hospital Center
Brooklyn, NY

Robert Oliver
Linn & Logan Consulting, Inc.
Brooklyn, NY

Stacie Williams
Vice President Human Resources
New York Presbyterian Hospital
New York, NY

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 the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Routine gynecological care for children through age 18	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Routine physical exams for adults age 19 and older	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Routine gynecological care for adults age 19 and older	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Immunizations	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met

	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 70% of the allowed amount after deductible is met	$10 copayment for initial visit only	Paid at 70% of the allowed amount after deductible is met
Inpatient Care	Room and board*	No cost	$500 copay/admission up to $1,000 max per individual or $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Physician's services*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Physician surgical services and anesthesia*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Restorative physical and occupational therapy*	No cost	$500 copay/admission up to $1,000 max per individual or $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Skilled Nursing Facility (up to 60 days per calendar year as medically neces-sary)*	No cost	$500 copay/admission up to $1,000 max per individual or $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%

*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 the allowed amount after deductible is met	$10 copay/visit PCP; $30 copay/visit specialist	Paid at 70% of the allowed amount after deductible is met
	Chiropractic care*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Acupuncture	$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Allergy treatment	$25 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Restorative physical, occupational, and cognitive therapy*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Cardiac rehabilitation*	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Radiology*	No cost	Paid at 70% of the allowed amount after deductible is met	$25 copayment	Paid at 70% of the allowed amount after deductible is met
	Laboratory tests*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Restorative speech therapy (up to 30 visits per calendar year)	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$30 copayment per visit	Paid at 70% of the allowed amount after deductible is met
	Surgery (physician's services)*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Surgery (facility charges)	No cost	Paid at 70%	No cost	Paid at 70%
	Physician surgical services and anesthesia*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Second surgical opinion	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Radiation, chemotherapy, and dialysis*	No cost	Paid at 70% of the allowed amount after deductible is met	No cost	Paid at 70% of the allowed amount after deductible is met
	Oxygen	Paid at 80%	Paid at 70% of billed charges (deductible does not apply)	Paid at 80%	Paid at 70% of billed charges (deductible does not apply)

*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 70% (deductible does not apply) 140 visit maximum	No cost	Paid at 70% (deductible does not apply) 140 visit maximum
	Home hospice care (up to 210 days max combined with inpatient hospice care)*	No cost	Paid at 70% (deductible does not apply)	No cost	Paid at 70% (deductible does not apply)
	Inpatient hospice care (up to 210 days max combined with home hospice care)*	No cost	$500 copay/admission up to $1,000 max per individual or $2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) Paid at 70%
	Durable medical equipment*	Paid at 80%	Paid at 70% of cost of covered items (deductible does not apply)	Paid at 80%	Paid at 70% of cost of covered items (deductible does not apply)
	Breast pumps (personal use, electric)	No cost	Paid at 70% (deductible does not apply)	No cost	Paid at 70% (deductible does not apply)
	Prosthetic devices, external*	Paid at 80%	Paid at 70% (deductible does not apply)	Paid at 80%	Paid at 70% (deductible does not apply)
	Orthotics	Paid at 80%	Paid at 70% of billed charges (deductible does not apply)	Paid at 80%	Paid at 70% of billed charges (deductible does not apply)
	Diabetic equipment*	$10 copay	Paid at 70% of cost of covered items after deductible is met	$10 copay	Paid at 70% of cost of covered items after deductible is met
	Diabetes education and nutritional counseling	$25 copayment	Paid at 70% of the allowed amount after deductible is met	$30 copayment	Paid at 70% of the allowed amount after deductible is met
	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 the allowed amount after deductible is met	No cost for IVF services; prescription copays may apply	Paid at 70% of the allowed amount after deductible is met
	Ambulance transport* (non-emergent)	Covered in full (if authorized)	Paid at 70% of the allowed amount (if authorized)	Covered in full (if authorized)	Paid at 70% of the allowed amount (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	Paid at 70% of the allowed amount after deductible is met	$30 copayment per office visit	Paid at 70% of the allowed amount after deductible is met
	Gym reimbursement	Partial reimbursement for participants ($200) and eligible dependents ($100) for completing 50 visits each six-month period (January-June and July-December) to an approved exercise facility.			
Mental Health	Outpatient mental health	$10 copayment/visit	Paid at 70% of the allowed amount after deductible is met	$10 copayment/ visit	Paid at 70% of the allowed amount after deductible is met
	Inpatient mental health care*	No cost	$500 copay/admission up to $1,000 max per individual /$2,000 max per family (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max/ individual (deductible does not apply) Paid at 70%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/alcohol addiction	$10 copayment per visit	Paid at 70% of the allowed amount after deductible is met	$10 copayment/ visit	Paid at 70% of the allowed amount after deductible is met
	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 (deductible does not apply) Paid at 70%	No cost	$500 copay/admission up to $1,500 max per individual (deductible does not apply) 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 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	Paid at up to $75 for exam and glasses or contact lenses (every two years)
	Eyeglasses or contact lenses every 2 years	$30 copay for lenses and/or frames within the Davis Frame Collection, or $150 credit toward non-plan frames, or $25 copay for formulary disposable/planned replacement lenses	

	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.	Coverage provides up to 12 weeks of leave at 67 percent of your average weekly wage, capped at 67 percent of the Statewide Average Weekly Wage (SAWW).

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 Anthem BlueCross BlueShield for your medical coverage, in addition to ID cards from Express Scripts Inc. 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 website. Aetna's member website is **aetna.com** and Davis Vision's website can be accessed at **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.

Newly hired participants are eligible for coverage as indicated in this chapter of the Summary Plan Description and your collective bargaining agreement.

Full-time employees

Effective date

Your coverage will become effective on your eligibility date, provided you submit an enrollment form to the Fund within 60 days of your date of hire 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 appears 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

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

- you and all of your dependents and spouse, or
- all, or any of your dependents and spouse,

as long as the individuals opting out of coverage under the Benefits Fund are covered under another group health plan or Medicaid and this is allowed by the other health plan. Your opt-out application, enrollment form, and supporting documentation, including proof of other coverage, must be received by the Fund office within 60 days of your date of hire. Proof of coverage must be a letter from the administrator of the group health plan or covered employee's human resources department. Insurance cards are not acceptable proof. You cannot opt out of coverage unless the information above is received and approved by the Fund office.

In addition, you may opt out a dependent eligible for Medicaid at any time. For these dependents, the effective date of the opt out is the first of the month following 30 days' notice of the opt out request to the Fund office.

Eligible employees approved by the Fund to opt out of health benefit coverage 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 if you have an involuntary loss of coverage, provided you request enrollment and provide proof of the loss of coverage (termination date and reason for termination) 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 dependents (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, a failure to re-enroll, or if there is an increase in cost, or a change in benefits. 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 **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

Effective date

Your coverage as a part-time employee will become effective on the day you become eligible for benefits, provided you authorize payroll deductions by your employer, if applicable.

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 below for more information on open enrollment).

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 for termination) must be received within 60 days after your other coverage ends.

Opting out of coverage

Some collective bargaining agreements allow part-time employees to opt out of coverage in the same manner as full-time employees. Please refer to the Full-time employee opt out section on the previous page for details about opting out of Benefits Fund coverage.

Open enrollment

The Benefits Fund's annual open enrollment period extends from November 1 through 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;
- Employees who didn't previously enroll in the Fund or authorize their employer to make payroll deductions, as applicable;
- Legal spouse and eligible dependents who were not added when they first became eligible.

If you choose not to enroll in the Benefits Fund or do not submit the required documents 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 previous page), request enrollment with the Fund, and provide proof of the loss of coverage (termination date and reason for termination) 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 or custodian 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, placement for adoption, foster placement, or appointment of guardianship or custody provided you request enrollment within 60 days of the qualifying event. If notification of a new dependent is not received within 60 days of the qualifying event, 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.

You must notify the Fund office of your new dependent and provide a copy of the marriage certificate (for spouse) or birth certificate (for dependent), as well as your spouse's or dependent's Social Security number.

On occasion the Benefits Fund may conduct an independent eligibility review to ensure that all spouses enrolled in the Fund meet the Fund's eligibility requirements. If you get notice of an eligibility review, you should cooperate as instructed in order to ensure that your spouse remains covered by the Benefits Fund.

Newborn children

You are responsible for enrolling your newborn dependent in the Benefits Fund within 60 days of their date of birth. You will be required to provide the dependent's social security number and a copy of their birth certificate when they are received in order to maintain Benefits Fund coverage for the dependent.

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 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 or unless custody or guardianship ends sooner. 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 over age dependent form provided to you by the Fund; proof of court-appointed guardianship of your disabled child, if available; and additional supporting 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 spouse or 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 spouse and dependents may be eligible for other coverage in some circumstances. See Chapter 7 of this SPD for more details.

Chapter 7: 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, paid family leave, 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:

- Their covered parent dies,
- Their covered parent experiences a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment,
- Their parents get a divorce or legal separation,
- Their covered parent enrolls in Medicare, or
- They cease 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 paid family leave, 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 depen-

dent 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. 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 earlier in 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 website at **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; or
- 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 8: 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 reduced.

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.)

Refer to Chapter 9: Medical Benefits and Chapter 11: Dental Benefits for additional details regarding coordination of benefits for these benefits.

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.

Anthem BlueCross BlueShield (Anthem) is a private health claims administrator that the Benefits Fund partners with to administer claims. Although Anthem 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 in the "Definitions" section at the end of the chapter.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in the "Definitions" section.

Whenever you need Covered Services, the Fund gives you a choice. Under the Fund, you can choose to receive Covered Services "In-Network" from Anthem's Participating Providers or you can receive Covered Services "Out-of-Network" from Non-Participating 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 Participating Providers, so it is important to try to use Participating 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 Participating Providers applicable to your Plan as indicated in the Schedule of Benefits chapter of this SPD (Page 14). You should first consider receiving health care services through Participating Providers under the In-Network Benefits portion of this SPD. Participating Providers have agreed to take Anthem's payment in full and you will not be Balance Billed. You will be responsible for your applicable Copayment or Coinsurance.

Use **anthem.com/find-care** to search for Participating Providers. It is your responsibility to confirm that the Provider or facility that you have selected is a Participating Provider at the time you receive services.

Out-of-Network Benefits

The Out-of-Network Benefits portion of this Fund provides coverage when you receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will generally be higher when you receive Out-of-Network Benefits. It is important to note that when you use a Non-Participating Provider, in addition to Cost-Sharing, you will also be responsible for any difference between the Allowed Amount and the Non-Participating Provider's charge.

How Your Coverage Works

A. Your Coverage Under this Plan

Your employer pays monthly contributions on your behalf for the benefits described in this SPD pursuant to collective bargaining agreements between NYSNA and your employer.

B. Covered Services

You will receive Covered Services under the terms and conditions of this Plan only when the Covered Service is:

- Listed as a Covered Service;
- Medically Necessary;
- Not in excess of any benefit limitations described in the Schedule of Benefits chapter of this SPD; and
- Received while your Plan is in force.

C. In-Network Services

As a Participant of the Plan, you may seek primary, preventative, or specialty care from any Participating 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 (Page 33), must be followed.

To receive the highest level of benefits, contact a Participating 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 a Participating Provider by going to **anthem.com/find-care** or by calling the Benefits Fund at (877) RN BENEFITS [762-3633].

Except for services covered by the No Surprises Act (Emergency services and services provided by a Non-Participating Provider at a Participating Hospital/Facility), and Preauthorized visits to a Non-Participating Provider, only services provided by a Participating Provider or Participating Hospital/Facility are Covered on an In-Network basis.

D. Access to Providers and Changing Providers

To help you find care from Participating Providers and Facilities, Anthem maintains a provider directory. Anthem updates its provider directory every 90 days and will respond to your inquiry about the network status of a provider or facility within one business day. Sometimes Providers in Anthem's Provider directory are no longer Participating Providers. It is your responsibility to confirm that the Provider or facility that you have selected is a Participating Provider at the time you receive services. If you make an inquiry and receive inaccurate information from Anthem or the Fund office about a Provider or facility's network status, you will be liable only for in-network cost sharing for the services underlying your inquiry.

To see a Provider, call his or her office and tell the Provider that you are an Anthem participant and explain the reason for your visit. Have your ID card available. The Provider's office may ask for your member ID number. When you go to the Provider's office, bring your ID card with you.

E. Out-of-Network Services

If you decide you do not want to use a Participating Provider, the Plan still provides coverage for a broad range of medical services. See the Schedule of Benefits chapter of this SPD (Page 14) for the Non-Participating Provider services that are Covered. 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-network services.

F. Services Subject to Preauthorization

Except in an Emergency, Preauthorization by Anthem is required before you receive certain Covered Services (see below). Your Provider, whether Participating or Non-Participating, should contact Anthem at the number on the back of your ID card to request Preauthorization and provide the supporting clinical documentation, as required. However, it is your responsibility to ensure Preauthorization has been obtained before receiving these services. If Preauthorization is not obtained or services are denied, you may be held financially responsible.

- All inpatient admissions, including maternity, admissions for illness or injury to newborns, and mental health and substance use disorder services
- Mental health and substance use intensive outpatient program services
- Mental health and substance use partial hospitalization program services
- Advanced Behavioral Analysis (ABA) services
- Transcranial Magnetic Stimulation (TMS)
- Skilled nursing facility
- Outpatient/ambulatory surgical treatments
- Physical and occupational therapy, and chiropractic services
- Diagnostic radiology services
- Therapeutic radiology services
- Durable medical equipment
- Prosthetics
- Gene therapy
- Non-emergent ground transportation and air ambulance service
- Specialty and infusion drugs covered under this medical benefit
- Dialysis services
- Genetic testing

This is a representative but not exhaustive list of services requiring Preauthorization. If you are unsure whether a procedure requires Preauthorization, please call the Benefits Fund.

G. Preauthorization/Notification Procedure

If you seek coverage for services that require Preauthorization or notification, you or your Provider must call Anthem at the number on your ID card.

You or your Participating Provider must contact Anthem to request Preauthorization as follows:

- At least two weeks prior to a planned admission or surgery when your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two weeks prior to ambulatory surgery or any ambulatory care procedure when your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Within the first three months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You or someone on your behalf must contact Anthem to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If you are hospitalized in cases of an Emergency Condition, you must call Anthem within 48 hours after your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, Anthem will review the reasons for your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

H. 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.

I. 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.

Anthem may base its decision on a review of:

- Your medical records;
- Anthem 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; and
- The opinion of health care professionals in the generally-recognized health specialty involved.

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; and
- 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 sections on Utilization Review and External Appeals on Pages 59-62 for your right to an internal appeal and external appeal of Anthem's determination that a service is not Medically Necessary.

J. Delivery of Covered Services Using Telehealth

If Your Provider offers Covered Services using telehealth, the Plan will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of this SPD that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Provider to deliver Covered Services to you while your location is different than your Provider's location.

K. Case Management

Case management helps coordinate services for participants with health care needs due to serious, complex, and/or chronic health conditions. Anthem's programs coordinate benefits and educate participants who agree to take part in the case management program to help meet

their health-related needs.

Anthem case management programs are confidential and voluntary. These programs are given at no extra cost to you and do not change Covered Services. If you meet program criteria and agree to take part, Anthem will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your authorized representative, treating Physician(s), and other Providers. In addition, Anthem may assist in coordinating care with existing community-based programs and services to meet your needs, which may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, Anthem may provide benefits for alternate care through our case management program that is not listed as a Covered Service. Anthem may also extend Covered Services beyond the benefit maximums of this Plan. Anthem will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis if Anthem determines the alternate or extended benefit is in the best interest of you and Anthem.

Nothing in this provision shall prevent you from appealing Anthem's decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Anthem to provide the same benefits again to you or to any other participant. Anthem reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, Anthem will notify you or your authorized representative in writing.

Compliance With The No Surprises Act

The following provisions of the No Surprises Act apply notwithstanding any contrary or inconsistent provisions in this SPD.

A. Emergency Services

The Plan provides coverage of Emergency services as required by the No Surprises Act as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care Provider furnishing the Emergency services is a Participating provider or a Participating Emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Non-Participating Emergency services that is more restrictive than the requirements or limitations that apply to Emergency services received from Participating Providers and Emergency facilities;

4. Without imposing cost-sharing requirements on Non-Participating Emergency services that are greater than the requirements that would apply if the services were provided by a Participating Provider or emergency facility;

5. By calculating the cost-sharing requirement for Non-Participating Emergency services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and

6. By counting cost-sharing payments you make with respect to Non-Participating Emergency services toward your Deductible and Out-of-Pocket Maximum in the same manner as those received from a Participating provider.

B. Non-Emergency Services Performed by a Non-Participating Provider at a Participating Facility

The Plan provides coverage of Non-Emergency services performed by a Non-Participating Provider at a participating health care facility as required by the No Surprises Act as follows:

1. With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Participating Provider;

2. By calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such Participating Provider were equal to the Recognized Amount for the items and services; and

3. By counting any Cost-Sharing payments made toward any Deductible and Out-of-Pocket Maximums applied under the Plan in the same manner as if such Cost-Sharing payments were made with respect to items and services furnished by a Participating Provider.

C. Notice and Consent Exception

Non-Emergency items or services performed by a Non-Participating Provider at a participating facility will be covered based on the Out-of-Network Cost-Sharing if:

1. At least 72 hours before the day of the appointment (or three hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Non-Participating Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any Participating Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Participating Providers listed; and

2. You give informed consent to continued treatment by the Non-Participating provider, acknowledging that you understand that continued treatment by the Non-Participating provider may result in greater cost to you.

The notice and consent exception does not apply to

Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Participating Provider satisfied the notice and consent criteria.

D. Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act, you may contact the federal government's No Surprises Act Helpdesk at (800) 985-3059 or the Employee Benefits Security Administration (EBSA) toll free number at (866) 444-3272. If you have a question about an explanation of benefits issued by the Plan, you may contact the Fund.

E. External Review Process of Certain Coverage Determinations

If your initial claim for benefits related to an Emergency Service and/or Non-Emergency Service provided by a Non-Participating Provider at a participating facility has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for independent external review of the determination. Please see "External Appeal" section on Page 62 or contact the Fund office for a copy of the Plan's External Review procedures.

Access To Care And Transitional Care

A. Authorization to a Non-Participating Provider

If Anthem determines that it does not have a Participating Provider that has the appropriate training and experience to treat your condition within a 50 mile radius, Anthem will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or you must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of you or another treating Provider and may not necessarily be to the specific Non-Participating Provider you requested. The Provider must agree to accept the negotiated fee as payment. If Anthem approves the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Anthem in consultation with your PCP, the Non-Participating Provider, and you. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit.

B. Your Provider Leaves the Network

If you are undergoing a course of treatment described below and your Provider leaves the Network, you may be able to continue to receive Covered Services for the ongoing treatment from your former Participating Provider for up to 90 days from the date your Provider's contractual obligation to provide services to you terminates (called "Continuing Care"). If you are pregnant and the Provider leaves the Network while you are in your second or third trimester, you may be able to continue care with a former Participating Provider through delivery and any post-partum care directly related to the delivery.

Services and conditions that are eligible for Continuing Care under this provision are (1) a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time); (2) a course of institutional or inpatient care from the provider or facility; (3) scheduled non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) pregnancy or a course of treatment for the pregnancy from the provider or facility; or (5) terminal illness (as defined in Section 1862(dd)(3)(A) of the Social Security Act) and treatment for such illness from such provider or facility.

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

Please note: *If the Provider was terminated by Anthem 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.*

C. New Participants Currently Undergoing a Course of Treatment

If you are undergoing a course of treatment with a Non-Participating Provider at the time your coverage under this Plan becomes effective, you may be able to receive Covered Services from the Non-Participating Provider for up to 60 days from the effective date of your coverage under the Plan. 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. If your coverage under this Plan becomes effective while you are in your second or third trimester of pregnancy, you may also continue care from your Non-Participating 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 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Anthem's fees for such services. The Provider must agree to provide Anthem necessary medical information related to your care and to adhere to all of Anthem's policies and procedures including those for assuring quality of care, obtaining Preauthorization, and a treatment plan approved by Anthem. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Participating Provider. You will only be responsible for any applicable Copayments.

Cost-Sharing And Allowed Amount

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

A. Deductible

Except where stated otherwise, you must pay the amount in the Schedule of Benefits chapter of this SPD for Covered Services during each Plan Year before the Plan provides out-of-network coverage. If you have other than individual coverage, the individual Deductible applies to each person covered under this Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Plan collectively total the family Deductible amount in the Schedule of Benefits section of this SPD in a Plan Year, no further Deductible will be required for any person covered under this Plan for that Plan Year.

B. Copayment

Except where stated otherwise, after you have satisfied the Deductible as described above, you must pay the Copayments, or fixed amounts, for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, you are responsible for the lesser amount.

C. Coinsurance

Except where stated otherwise, after you have satisfied the Deductible described above, you must pay a percentage of the Allowed Amount for Covered Services. Anthem will pay the remaining percentage of the Allowed Amount as your benefit as shown in the Schedule of Benefits chapter of this SPD.

You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount. See "Additional Payments for Out-of-Network Benefits" below.

D. Out-of-Pocket Maximum

When you have met your Out-of-Pocket Maximum in payment of In-Network Copayments and Coinsurance for a Plan Year, the Plan will provide coverage for 100 percent of the contracted amount for Covered Services for the remainder of that Plan Year. If you have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Maximum, the Plan will provide coverage for 100 percent of the contracted amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Plan 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 contracted amount for the rest of that Plan Year for the entire family. You will not have to pay any further Copayments or Coinsurance for the remainder of the Plan Year. There is no Out-of-Pocket Maximum for Out-of-Network Covered Services.

E. Additional Payments for Out-of-Network Benefits

When you receive Covered Services from a Non-Participating Provider, in addition to the applicable Deductible and Coinsurance, you must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds the Allowed Amount ("Balance Billed Amount"). This means that the total of the Plan's coverage and any Cost-Sharing amounts you pay may be less than the Non-Participating Provider's actual charge. Note that under the No Surprises Act, if you received non-emergency services provided by Non-Participating Provider at a Participating Hospital/Facility, you are not responsible for the Balance Billed Amount unless you consented to be treated by the Non-Participating Provider.

When you receive Covered Services from a Non-Participating 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 codes 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. Anthem will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when Anthem 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 Anthem receives a claim that does not have the correct modifier, Anthem will change it and make the appropriate payment. Additionally, another example of when Anthem will apply a payment rule to a claim is when you receive services from a Health Care Professional who is not a Physician, such as a physician's assistant. Under the payment rule, the Allowed Amount for a physician's assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.

F. Allowed Amount

Allowed Amount means the maximum amount the Plan will pay for the services or supplies Covered under this Plan, before any applicable Copayment, Deductible, and Coinsurance amounts are subtracted. Anthem determines its Allowed Amount as follows.

The Allowed Amount for Participating Providers will be the amount Anthem has negotiated with the Participating Provider or the amount approved by another Host Plan (See below for more information about Host Plans), or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. Facilities. For Facilities, the Allowed Amount will be the average amounts paid by Anthem for comparable services to Anthem Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Anthem for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.

2. All Other Providers. For all other Providers, the Allowed Amount applicable to this Plan is the 70th percentile of the Fair Health rate.

See the Inter-Plan Program section below for a description of how Anthem determines the Allowed Amount for Non-Participating Providers outside the Service Area.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible. The Non-Participating Provider's actual charge may exceed Anthem's Allowed Amount and you must pay this difference between Anthem's Allowed Amount and the Non-Participating Provider's charge. Contact the Benefits Fund at (877) RN BENEFITS [762-3633] or go to **anthemblue.com** for more information on your financial responsibility when you receive services from a Non-Participating Provider.

Anthem reserves the right to negotiate a lower rate with Non-Participating Providers or to pay another Host Plan's rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

See the Emergency Services section of this chapter for the Allowed Amount for an Emergency Condition. Such amounts are subject to the No Surprises Act.

G. Inter-Plan Programs

1. Out-of-Area Services. Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called Inter-Plan Arrangements. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access healthcare services outside the geographic area Anthem serves ("Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain below how Anthem pays both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above.

2. BlueCard® Program. Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill its contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this negotiated price will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average sav-

ings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments, and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Anthem used for your claim because they will not be applied after a claim has already been paid.

3. Negotiated (non-BlueCard Program) Arrangements. With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for covered services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section B. BlueCard Program) made available to Anthem by the Host Plan.

4. Non-Participating Providers Outside the Service Area. When Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment, or Coinsurance will be based on that allowed amount. Also, except for services covered by the No Surprises Act, you may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

H. Blue Cross Blue Shield Global Core® Program.

If you plan to travel outside the United States, call the Fund at (877) 762-3633 to find out about your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency services, including ambulance and Urgent Care, outside of the United States. Remember to take your ID card with you when you travel.

When you're traveling abroad and need medical care, you may call the Blue Cross Blue Shield Global Core® Service Center any time. The center is available 24 hours a day, seven days a week by calling (800) 810-2583 or calling collect at (804) 673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact Anthem for Preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

How claims are paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance, or Deductible amounts that may apply. You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front. When you need Blue Cross Blue Shield Global Core® claim forms, you can get international claim forms by:

- Calling the Blue Cross Blue Shield Global Core® Service Center at the numbers above;
- Going online to **bcbsglobalcore.com**; or
- Calling the Benefits Fund at (877) RN BENEFITS [762-3633].

Preventive Care

The Plan Covers preventative services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF); or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply.

A. Well-Baby and Well-Child Care. The Plan Covers well-baby and well-child care, which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also Covers preventive care and

screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one well-child visit per Plan Year, Anthem will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to participants from birth through attainment of age 21 and is not subject to Copayments when provided by a Participating Provider.

B. Adult Annual Physical Examinations. The Plan Covers adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, lung cancer screening, colorectal cancer screening, and diabetes screening. A complete list of the Covered preventive services is available at **anthem.com**.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. The Plan Covers adult immunizations as recommended by ACIP. This benefit is not subject to Copayments when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. The Plan Covers well-woman examinations, which consist of a routine gynecological examination, breast examination, and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available at **anthem.com.**

This benefit is not subject to Copayments when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.

E. Mammograms. The Plan Covers mammograms for the screening of breast cancer as follows:

- One baseline screening mammogram for women age 35 through 39; and
- One baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, the Plan Covers mammograms as recommended by the Provider. However, in no event will more than one preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles, or Coinsurance.

F. Family Planning and Reproductive Health Services. The Plan Covers family planning services, which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this SPD; device insertion and removal; sterilization procedures for women and men; and patient education and counseling on the use of contraceptives and related topics. Such services are not subject to Copayments when provided by a Participating Provider. Some follow-up services may be subject to Copayments. The Plan does not Cover services related to the reversal of elective sterilizations.

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 family planning and reproductive health services.

G. Bone Mineral Density Measurements or Testing. The Plan Covers bone mineral density measurements or tests. Bone mineral density measurements or tests or devices shall include those covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if you meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if you meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the

presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

The Plan also Covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. This benefit is not subject to Copayments.

H. Screening for Prostate Cancer. The Plan Covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. The Plan also Covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments when provided by a Participating Provider.

I. Screening for Colon Cancer. The Plan Covers colon cancer screening for participants aged 45 through 75, including all colon cancer exams or laboratory tests in accordance with the USPSTF and any additional screenings recommended by the American Cancer Society guidelines for average risk individuals. Coverage includes an initial colonoscopy or other medical tests for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventative screening test.

This benefit is not subject to Copayments when provided by a Participating Provider in accordance with the recommendations of USPSTF but may be subject to copayments for additional screenings provided in accordance with the American Cancer Society guidelines.

Ambulance And Pre-Hospital Emergency Medical Services

Pre-hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization. The Plan covers pre-hospital Emergency Medical Services and Emergency ambulance transportation worldwide.

A. Emergency Ambulance Transportation

1. Pre-hospital Emergency Medical Services

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,
- In the case of a behavioral condition, placing the health of a 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.

A Participating ambulance service must hold you harmless and may not charge or seek reimbursement from you for pre-hospital Emergency Medical Services. In the absence of negotiated rates, the Plan will pay a Non-Participating Provider the Allowed Amount for pre-hospital Emergency Medical Services, which shall not be excessive or unreasonable. The Allowed Amount for Pre-Hospital Emergency Medical Services is the lesser of the FAIR Health rate at the 70th percentile or the Provider's billed charges.

2. Emergency Ambulance Transportation

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. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat your Emergency Condition.

B. Non-Emergency Ambulance Transportation

The Plan covers pre-authorized 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 a Non-Participating Hospital to a Participating 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 care Facility to a sub-Acute setting.

Preauthorization is required for non-emergency ambulance services.

C. 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 Anthem, 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.

A. 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 a Participating 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 Anthem's service area at the time your Emergency Condition occurs.

1. 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.

2. Emergency Hospital Admissions. In the event you're admitted to the Hospital, you or someone on your behalf must notify Anthem 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 following Emergency Department Care at a Non-Participating Hospital at the In-Network Cost-Sharing. If your medical condition permits your transfer to a Participating Hospital, Anthem will notify you and arrange the transfer.

3. Payments Relating to Emergency Services Rendered. The amount Anthem pays a Non-Participating Provider for Emergency Services (the "Recognized Amount") must comply with the No Surprises Act and its regulations, and will be the greater of: 1) the amount Anthem has negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100 percent of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount Anthem would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment that applies to Emergency Services provided by a Participating Provider.

4. If you receive Emergency Services from a Non-Participating Provider, your Cost-Sharing will be

the same as if you had received those services from a Participating Provider. This means that you will not have to satisfy the Out-of-Network Deductible, Copayment, or Coinsurance for these services and you will not have to pay the amount billed by the Non-Participating Provider that exceeds the Plan's normal Allowed Amount for the Covered Service. Instead, you will only pay the In-Network Cost-Sharing, which generally is only the In-Network Copayment. Refer to the No Surprises Act section for additional information.

B. 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. If you need care after normal business hours, including evenings, weekends or holidays, you have options. You can call your Provider's office for instructions or visit an Urgent Care Center. If you have an Emergency Condition, seek immediate care at the nearest Hospital emergency department, a freestanding emergency facility, or call 911. Urgent Care is Covered in or out of Anthem's service area.

1. In-Network. The Plan Covers Urgent Care from a Participating Provider or participating Urgent Care Center. You don't need to contact Anthem prior to or after your visit.

2. Out-of-Network. The Plan Covers Urgent Care from Non-Participating Urgent Care Centers or Physicians. You don't need to contact Anthem prior to or after your visit.

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. Acupuncture Services. The Plan Covers acupuncture services rendered by a Health Care Professional licensed to provide such services only for pain management and relief of nausea related to cancer or pregnancy.

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

C. 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.

D. 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.

E. Chemotherapy and Immunotherapy. The Plan Covers chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. 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 74).

F. Chiropractic Services. The Plan Covers chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") 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.

G. 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 a Participating 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 treatment; 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.

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

The Plan also Covers dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Anthem's Service Area.
- The Participating Provider who is treating you has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Anthem 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 Anthem has a reasonable opportunity to review your travel and treatment plans.
- The Plan has the right to Preauthorize the dialysis treatment and schedule. Preauthorization is required if you receive dialysis treatment out of the country.
- The Plan will provide benefits for no more than 10 dialysis treatments by a Non-Participating Provider per participant per calendar year.

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

Dialysis treatments received out of the country are covered only in emergent and Urgent Care situations if deemed Medically Necessary and Preauthorized by Anthem.

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.*

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. 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. 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.

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
- 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
- Intrauterine insemination
- Hysteroscopy
- Laparoscopy
- Laparotomy

Advanced Reproductive Technologies (ART) Services
The following services are covered under the provisions of this Plan to Covered participants who have failed to achieve a pregnancy after 12 months of appropriate, timed unprotected intercourse or therapeutic donor insemination (or six months for women age 35 and over). These services are limited to a lifetime maximum of $5,000 in medical or prescription drugs. Medical and prescription drug benefits cannot be combined.
1. The following advanced reproductive technology services are covered with a diagnosis of infertility:

- in-vitro fertilization (IVF)
- frozen embryo transfer (FET)
- gamete intrafallopian transfer (GIFT)
- zygote intrafallopian transfer (ZIFT)
- intracytoplasmic sperm injection (ICSI)

2. Medically necessary and appropriate diagnostic workup and radiology services.
3. Pathology and laboratory services, including:

- Hormonal assays
- Swimup semen analysis, as appropriate
- Ultrasound exams
- Fertilization and embryo culture
- Ova retrieval
- Embryo, gamete-zygote transfer
- Cryropreservation of blastocysts(s) and embryo(s) from covered IVF cycles and oocytes as directed by medical policy and up to the age of 45.

4. All frozen embryos stored after a completed cycle with ovarian stimulation must be utilized prior to coverage availability for another ovarian stimulation cycle. Embryo transfer guidelines per the American Society of Reproductive Medicine should be followed for all embryo transfers (fresh and frozen cycles) and elective single embryo transfer should be utilized when clinically appropriate.

Exclusions and Limitations. The Plan does not Cover:

- Related donor expenses for donated oocytes or sperm, including all medical expenses, travel expenses, agency, laboratory and donor fees, psychological screening, FDA testing for the donor and partner, genetics screening and all medications for the donor (e.g. suppression medications, stimulation medications)
- Fallopian tube ligations and vasectomy reversals
- Surrogacy and any fees associated with it (maternity services are covered for participants acting as a surrogate mother)
- Medical and surgical procedures that are experimental or investigational
- Services requested which are not medically appropriate
- Services not specifically listed as covered directly above

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.

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). The Plan Covers elective 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 Radiology 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.

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 based on medical necessity), 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 chapter (Page 51) for Coverage of inpatient maternity care.

The Plan Covers breastfeeding support and counseling, including the purchase of one personal use electronic breast pump per pregnancy for the duration of breastfeeding from a Participating Provider.

O. Medications for Use in the Office. The Plan Covers medications (excluding self-injectable drugs) used by your Provider in the Provider's office for preventive and therapeutic purposes. This benefit applies when your Provider orders the prescription drug and administers it to you.

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

Q. Outpatient Hospital Services. The Plan Covers Hospital services and supplies as described in the Inpatient Services section of this chapter (see Page 51) 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.

R. 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 7 days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Rehabilitation Services. The Plan Covers Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility if surgery is performed or in a healthcare professional's office. Refer to the Schedule of Benefits chapter of this SPD (Page 14) to determine if a limit applies.

T. Retail Health Clinics. The Plan Covers basic health care services provided to you on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses.

U. 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 a Non-Participating Provider on an In-Network basis when your attending Physician provides a written authorization to a Non-Participating 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 Anthem Preauthorizes a surgical procedure. There is no cost to you when Anthem 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 recommended course of treatment. In such cases, you may request that Anthem designate another Provider to render a second opinion. If the first and second opinions do not agree, Anthem will designate another Provider to render a third opinion. After completion of the second opinion process, Anthem will Preauthorize Covered Services supported by the majority of the Providers reviewing your case.

V. Surgical Services. The Plan Covers Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, closed reduction of fractures and dislocations of bones, endosco-

pies, incisions, or punctures of the skin on an inpatient and outpatient basis. This includes 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.
- 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.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.
- Boney impacted wisdom teeth extraction as secondary to dental coverage.

X. Reconstructive Breast Surgery. The Plan Covers breast reconstructive surgery after a mastectomy or a partial mastectomy. Coverage includes:

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

Y. 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;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection, or disease of the involved part; or
- Otherwise Medically Necessary.

Z. Telemedicine Program. In addition to providing Covered Services via telehealth, the Plan Covers online internet consultations between you and Providers who participate in Anthem's telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Anthem's telemedicine program. You can check the Provider directory or contact the Benefits Fund for a listing of the Providers that participate in the telemedicine program.

1. Online visits. Your coverage includes online physician office visits. Covered Services include a medical consultation using the internet via a webcam with online chat or voice functions. Services are provided by board certified, licensed Primary Care Physicians. Common types of diagnoses and conditions treated online include cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis, and urinary tract infections, when uncomplicated in nature.

2. Access. To begin the online visit, log on to **livehealthonline.com** and establish an online account by providing some basic information about you and your plan. Before you connect to a Provider, you'll be asked to identify the kind of condition you want to discuss with the Provider; list your local pharmacy; provide credit card information; agree to the terms of use; and select an available Provider. If you're not in New York State when you seek an online visit, you'll need to check to be sure an online Provider is available in the state you're in because online

Providers are not available in every state.

The visit with the Provider will not start until you provide the above information and click "connect." The visit will be documented in an electronic health record. You may access your records and print them, and may email or fax them to your Primary Care Physician.

Online visits are not meant for the following purposes:

- To get reports of normal lab or other test results;
- To request an office appointment;
- To ask billing, insurance coverage, or payment questions;
- To ask for a referral to a specialist Doctor;
- To request preauthorization for a benefit under the Plan; or
- To ask the Physician to consult with another Physician.

AA. 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, pancreas, 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 Anthem has specifically approved and designated to perform these procedures. The Plan will Cover the cost of reasonable and necessary travel costs with prior approval if the Participant needs to travel more than 100 miles from the Participant's permanent home to reach the approved facility where the transplant will be performed.

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.

Preauthorization is required for a transplant. Your Provider must certify, and Anthem must agree, that the transplant is Medically Necessary. Your Provider should send a written request for Preauthorization to Anthem as soon as possible to start this process.

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 of stem cells from newborn cord blood.

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. Diabetic Equipment, Supplies, and Self-Management Education. The Plan Covers diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law 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
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Glucagon for injection to increase blood glucose concentration
- Glucose Acetone Reagent Strips
- Glucose Kit
- 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
- Glucose Reagent Tape
- Glucose Strips (Test or Reagent)
- Injection Aides
- Injector (Busher) Automatic
- Insulin Cartridge Delivery
- Insulin Infusion Devices (Preauthorization is required for this item)
- Insulin Pump and equipment for its use
- Lancets
- Oral agents such as glucose tablets or gels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

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.

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.

B. 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:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

Coverage is for standard equipment only. The Plan Covers the cost of repair or replacement when made necessary by normal wear and tear. 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 Anthem.

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.

C. Enteral Nutrition. The Plan Covers Medically Necessary enteral nutrition (administered orally or via tube feeding) if Anthem's clinical guidelines are met. It is not Covered if deemed not Medically Necessary. Nutritional supplements that are taken electively, are used for convenience, or for features that exceed Medical Necessity are not Covered.

Nutritional Formulas

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

D. Treatment of Gender Dysphoria. The Plan pays Benefits for the treatment of gender dysphoria as described under "Non-Surgical treatment" or "Surgical treatment" 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 74.*

- 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.

E. Hospice. Hospice Care is available if your primary attending Physician has certified that you have 12 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; and homemaker or caretaker care.

F. 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 48 for a description of diabetic supply Coverage.

G. Orthotics. The Plan Covers custom fitted orthotics and custom molded orthotic appliances that are necessary to:
- support, restore, or protect body function;
- redirect, eliminate, or restrict motion of an impaired body part; or
- relieve or correct a condition caused by an injury or illness.

The Plan Covers replacements due to:
- a change in your condition; or
- when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or
- when there has been an irreparable change in the condition of the device due to normal wear and tear.

The Plan does not Cover the cost of repair or replacement that is the result of misuse or abuse by the Participant.

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 mastectomy or partial mastectomy in a manner determined by you and your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage is for standard equipment only and must be Preauthorized.

External Prosthetic Devices. The Plan Covers prosthetic devices (including wigs) that are worn externally and temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an Injury or disease. The Plan Covers wigs 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). The Plan does not Cover wigs made from human hair unless you are allergic to all synthetic wig materials.
- The Plan does not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.
- The Plan does not Cover eyeglasses or contact lenses.
- External breast prostheses following a mastectomy also are Covered and are not subject to any lifetime benefit.
- Coverage is for standard equipment only.
- Replacements for external prosthetics 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.

Inpatient Services

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:

- 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 for the same or related causes.

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. 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. Rehabilitation Services. The Plan Covers Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy. Physical and occupational therapy are covered as Medically Necessary while speech therapy is covered for up to 30 visits per calendar year.

H. 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 54). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Anthem. The Plan Covers non-custodial care for up to 60 days per calendar year.

I. 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 Non-Participating Providers for this end of life care as follows:

- The Plan will reimburse a rate that has been negotiated between Anthem 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.

J. 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 and 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.

A. Mental Health Care Services

The Plan Covers the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

Inpatient Services. The Plan Covers inpatient mental healthcare services relating to the diagnosis and treatment of mental health conditions 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; or
- 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 health conditions 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 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Health Law Article 30; 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 health conditions comparable to other similar medical and surgical coverage provided under this SPD. 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 New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities. Services must provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; licensed nurse practitioner; a licensed mental health counselor; or a professional corporation or a university faculty practice corporation.

B. Autism Spectrum Disorder. The Plan Covers the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist 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, including Advanced Behavioral Analysis(ABA), 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, Board-Certified Behavioral Analysts, 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.

C. Substance Use Services. The Plan Covers the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

Inpatient Services. The Plan Covers inpatient substance use services relating to the diagnosis and treatment of substance use disorder comparable to other similar inpatient medical and surgical coverage provided under this SPD. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State that are licensed, certified, or otherwise authorized by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states, to those Facilities that are licensed, certified, or otherwise authorized by a similar state agency and 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 substance use disorder, and dependency received at Facilities that provide residential treatment, including room and board charges.

Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by a state agency and accredited by the Joint Commission or a national accreditation organization recognized by Anthem 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 substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified, or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified, or otherwise authorized by the Joint Commission or a national accreditation organization recognized by Anthem 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 outpatient visits 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.

Exclusions And Limitations

No coverage is available under the Plan for the following:
1. Medically Necessary. In general, the Plan will not Cover any health care service, procedure, treatment, test, or device that Anthem determines is not Medically Necessary. If an External Appeal Agent certified by the State overturns Anthem'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 or device is otherwise Covered under the terms of this SPD

2. Cosmetic Services. The Plan will not Cover cosmetic services or surgery unless otherwise specified, except that 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. The Plan also Covers services in connection with reconstructive surgery following a mastectomy, as outlined elsewhere in this chapter. Cosmetic surgery does not include surgery determined to be Medically Necessary.

3. Comfort or convenience items. The Plan 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; or mattresses.

4. 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.

5. 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.

6. 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. Note that the No Surprises Act may not apply to some or all of your expenses incurred due to an emergency outside of the United States.

7. 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 43).

8. Weight Control. The Plan does not Cover membership in health clubs, diet plans, or clubs even if recommended by a Physician or any other Provider for purpose of losing weight; stays at special facilities or spas; and any services, supplies, programs, special foods, diet aids and supplements related to dieting.

9. 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; hearing aids; tilt tables; special supplies or equipment; or special appliances.

10. Experimental or Investigational Treatment. The Plan does not Cover any health care service, procedure, treatment, or device 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 43), when Anthem'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 chapter for a further explanation of your Appeal rights

11. 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;
- 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.

12. 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, unless you are taken to the Hospital because it is close to the place where you were injured or became ill and Emergency Services are provided to treat your Emergency Condition.

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

14. 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.

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

16. Medications. The Plan does not Cover outpatient prescription drugs; growth hormone therapy; over-the-counter drugs and treatments; self-injectable medications, except for drugs for the treatment of diabetes and medications which, due to their characteristics (as determined by Anthem), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting; and non-injectable medications given in a Physician's office, other than such medications that are required in a Medical Emergency and consumed in the Physician's office.

17. 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 (for example diabetes) resulting in circulatory deficits or areas of decreased sensation in your legs or feet.

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

19. 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 Anthem 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.

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

21. Special foods and diets, supplements, and vitamins. Infant formulas are not Covered.

22. 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.

23. Felony Participation. The plan does not Cover any illness, treatment, or medical condition due to your participation in a felony, riot, or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

24. Vision Services. The Plan does not cover the examination or fitting of eyeglasses, contact lenses, or vision therapy.

25. War. The Plan does not Cover an illness, treatment, or medical condition due to war, whether declared or undeclared.

26. 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.

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

28. 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.

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

30. Services with no charge. The Plan does not Cover services for which no charge is normally made.

31. 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.

32. Conversion Therapy. The Plan does not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a participant under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Claim Determinations

A. Claims. A claim is a request that benefits or services be provided or paid according to the terms of this SPD. When you receive services from a Participating Provider, you will not need to submit a claim form. However, if you receive services from a Non-Participating Provider, either you or the Provider must file a claim form with Anthem. If the Non-Participating Provider is not willing to file the claim form, you will need to file it with Anthem. See the Coordination of Benefits section of this SPD for information on how Anthem coordinates benefit payments when you also have health coverage with another plan.

B. Notice of Claim. Claims for services must include all information designated by Anthem as necessary to process the claim, including, but not limited to:

- Participant identification number
- Name
- Date of birth

- Date of service
- Type and place of service
- Charge for each service
- Procedure code for the service as applicable
- Diagnosis code
- Name, tax identification number, and address of the Provider making the charge
- Supporting medical records, when necessary.

A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from the Fund by calling (877) RN BENEFITS [762-3633] or visiting the Fund's website at **rnbenefits.org**. You may also submit claims directly through the Sydney App or the **anthem.com** member portal.

C. Timeframe for Filing Claims. Claims for services provided by Participating Providers must be submitted to Anthem for payment within 90 days after you receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 90-day period, you must submit it as soon as reasonably possible. Claims for services received from a Non-Participating Provider must be submitted within 180 days.

D. Claims for Prohibited Referrals. The Plan is not required to pay any claim, bill, or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services, or x-ray or imaging services that a Provider could not lawfully make.

E. Pre-Service Claim Determinations

Pre-service claims. A pre-service claim is a request that a service or treatment be approved before it has been received. If Anthem has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), it will make a determination and provide notice to you (or your designee) within 15 days from receipt of the claim.

If additional information is needed, Anthem will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If Anthem receives the information within 45 days, it will make a determination and provide notice to you (or your designee) in writing within 15 days of its receipt of the information. If all necessary information is not received within 45 days, Anthem will make a determination within 15 calendar days of the end of the 45 day period.

Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if Anthem has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision.

If Anthem needs additional information, it will request it within 24 hours. You will then have 48 hours to submit the information. Anthem will make a determination and provide notice to you (or your designee) by telephone within 48 hours of the earlier of its receipt of the information or the end of the 48-hour period. Written notice will follow within three calendar days of the decision.

F. Post-Service Claim Determinations. A post-service claim is a request for a service or treatment that you have already received. If Anthem has all information necessary to make a determination regarding a post-service claim, it will make a determination and notify you (or your designee) within 30 calendar days of the receipt of the claim if Anthem denies the claim in whole or in part.

If additional information is needed, Anthem will request it within 30 calendar days. You will then have 45 calendar days to provide the information. Anthem will make a determination and provide notice to you (or your designee) in writing within 15 calendar days of the earlier of its receipt of the information or the end of the 45-day period if Anthem denies the claim in whole or in part.

Claim Denials

If your claim is denied, whether in whole or in part, you will be provided with written notice of a denial of the claim by the appropriate claims administrator. This notice will state:

- The specific reason(s) for the determination, including denial codes and their corresponding meaning;
- Reference to the specific Plan's provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- Any new or additional evidence the Plan considered, relied upon, or generated in connection with the claim that is available upon your request at no charge;
- If an internal rule, guideline or protocol was relied

upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon your request at no charge; and

- If the determination was based on Medical Necessity or because the treatment was experimental or investigational, or other similar exclusion (see Utilization Review), upon request, you will receive an explanation of the scientific or clinical criteria used in the determination and applied to the terms of the Plan to your claim at no charge within 30 days of you, your Dependent(s)' or either of your authorized representative's request.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. You will be notified of any benefit determinations, whether adverse or not, involving Urgent Care Claims within 72 hours of receipt of the claim by the claims administrator. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.
- For all Pre-Service Claims (including Urgent Care Claims), you will receive notice of the determination even when the claim is approved.

You will then be entitled, upon written request, to a review of that claim decision.

For purposes of this Claims Procedure section, the Grievance Procedures section and the Utilization Review Procedures section, "adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit and includes a Rescission of Coverage, whether or not there is an adverse effect on any particular benefit. This applies to an appeal under either the Grievance Procedures or the Utilization Review Internal Appeals procedures described below.

Grievance Procedures

A. Grievances. Anthem's Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Anthem and issues that are not adverse benefit determinations. For example, it applies to contractual benefit denials as well as issues or concerns you have regarding Anthem's administrative policies or access to providers. Note that if your issue does not involve an adverse benefit determination of a claim, it is not subject to the time frames in this Claims Procedure section or the sections governing first and second level appeals.

B. Filing a Grievance. You may contact Anthem in writing to file a Grievance. You may submit a Grievance in connection with a denial of a Referral or a covered benefit determination. You or your designee have up to 180 calendar days from when you received the decision you are asking Anthem to review to file a Grievance. You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Anthem will keep all requests and discussions confidential and will take no discriminatory action because of your issue. Anthem has a process for both standard and expedited Grievances, depending on the nature of your inquiry. Grievances should be submitted in writing to:

Grievances and Appeals
PO Box 1407
Church Street Station
New York, NY 10008-1407

C. Grievance Determination. Qualified Anthem personnel will review your Grievance, or if it is a clinical matter, a licensed, certified, or registered Health Care Professional will look into it. Anthem will decide the Grievance and if it involves an adverse benefit determination, will notify you within the following timeframes:
Expedited/Urgent Grievances: By phone, 72 hours of receipt of your Grievance. Written notice will be provided within 72 hours of receipt of your Grievance.
Pre-Service Grievances (a request for a service or treatment that has not yet been provided): In writing, within 15 calendar days of receipt of your Grievance.
Post-Service Grievances (a claim for a service or treatment that has already been provided): In writing, within 30 calendar days of receipt of Your Grievance.
All Other Grievances (that are not in relation to a claim or request for a service or treatment): Call the Benefits Fund at (877) RN BENEFITS [762-3633].

D. Grievance Appeals. If you are not satisfied with the resolution of your Grievance, you or your designee may file an Appeal by phone at the number on your ID card or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

As a reminder, a Grievance does not involve Medical Necessity or investigational or experimental claims, and as such, is not eligible for External Review unless the No Surprises Act applies.

If your Grievance concerned a claim for benefits, you have the right to review, free of charge, all documents,

records, and other information relevant to your claim. A document, record, or other information is relevant if it was relied upon in making the decision; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund office's or Anthem's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service. A document, record, or other information is relevant if it was relied upon in making the decision; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund office's or Anthem's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the claims administrator responsible for the claim, without regard to whether their advice was relied upon in deciding your claim.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. Anthem will decide the Appeal and notify you in writing within the following timeframes:

Expedited/Urgent Grievances: Written notice will be provided within 72 hours of receipt of your Grievance.

Pre-Service Grievances (a request for a service or treatment that has not yet been provided): 15 calendar days of receipt of your Appeal.

Post-Service Grievances (a claim for a service or treatment that has already been provided): 30 calendar days of receipt of your Appeal.

All Other Grievances (that are not in relation to a claim or request for a service or treatment): 30 business days of receipt of all necessary information to make a determination.

Utilization Review

A. Utilization Review. Anthem reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational. This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the Utilization Review process, you may call the Benefits Fund at (877) RN BENEFITS [762-3633].

All determinations regarding Medical Necessity will be made by:

- Licensed physicians;
- Licensed, certified, registered, or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages your medical condition or disease or provides the health care service under review; or
- With respect to mental health or substance use disorder treatment, licensed physicians or licensed, certified, registered, or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment.

Anthem does not compensate or provide financial incentives to its employees or reviewers for determining that services are not Medically Necessary.

Anthem has developed guidelines and protocols to assist in this process and will use evidence-based and peer-reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for your review upon request. For more information, call the Benefits Fund at (877) RN BENEFITS [762-3633] or visit **anthem.com**.

B. Preauthorization Reviews

Non-Urgent Preauthorization Reviews. If Anthem has all the information necessary to make a determination regarding a Preauthorization review, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 15 calendar days of receipt of the request.

If additional information is needed, Anthem will request it within 15 calendar days. You or your Provider will then have 45 calendar days to submit the information. If Anthem receives the requested information within 45 days, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 15 calendar days of receipt of the additional information. If all necessary information is not received within 45 days, Anthem will make a determination within 15 calendar days of the end of the 45-day period allowed to submit the additional information.

Urgent Preauthorization Reviews. With respect to urgent Preauthorization requests, if Anthem has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 72 hours of receipt of the request.

If additional information is needed, Anthem will

request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Anthem will make a determination and provide notice to you (or your designee) and your Provider, in writing, within 48 hours of the earlier of Anthem's receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

C. Concurrent Reviews

Non-Urgent Concurrent Reviews. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) and your Provider, in writing, within 15 calendar days of the receipt of all necessary information.

If additional information is needed, Anthem will request it within 15 calendar days of the receipt of the request. You or your Provider will then have 45 calendar days to submit the additional information. Anthem will make a determination and provide written notice to you (or your designee) and your Provider within 15 calendar days of its receipt of the additional information or, if the information is not received, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

Urgent Concurrent Reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, Anthem will make a determination and provide notice to you (or your designee) and your Provider within 24 hours of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, Anthem will make a determination and provide written notice to you (or your designee) and your Provider within 72 hours of receipt of the request. If additional information is needed, Anthem will request it within 24 hours. You or your Provider will then have 48 hours to submit the information. Anthem will make a determination and provide written notice to you (or your designee) and your Provider within the earlier of one business day or 48 hours of Anthem's receipt of the information or, if Anthem does not receive the information, within 48 hours of the end of the 48-hour period.

Inpatient Substance Use Disorder Treatment Reviews. If a request for inpatient substance use disorder treatment is submitted to Anthem at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, Anthem will make a determination within 24 hours of receipt of the request and will provide coverage for the inpatient substance use disorder treatment while its determination is pending.

D. Retrospective Reviews. If Anthem has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify you and your Provider within 30 calendar days of the receipt of the request. If additional information is needed, Anthem will request it within 30 calendar days. You or your Provider will then have 45 calendar days to provide the information. Anthem will make a determination and provide notice to you and your Provider in writing within 15 calendar days of the earlier of Anthem's receipt of all or part of the requested information or the end of the 45-day period.

Once Anthem has all the information to make a decision, a failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services. Anthem may only reverse a preauthorized treatment, service, or procedure on retrospective review when:

- The relevant medical information presented upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented upon retrospective review existed at the time of the Pre authorization but was withheld or not made available to Anthem;
- Anthem was not aware of the existence of such information at the time of the Preauthorization review; and
- Had Anthem been aware of such information, the treatment, service, or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria, or procedures as used during the Preauthorization review.

F. Reconsideration. If Anthem did not attempt to consult with your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your Provider and in writing.

G. Utilization Review Internal Appeals. You, your designee, and, in retrospective review cases, your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an Appeal. Anthem will acknowledge your request for an internal Appeal, which will include the name, address, and phone number of the person handling your Appeal and, if necessary, inform you of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is either a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information is relevant if it was relied upon in making the decision; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund Office's or Anthem's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the claims administrator responsible for the claim, without regard to whether their advice was relied upon in deciding your claim.

H. First Level Appeal.

Preauthorization Appeal. If your Appeal relates to a Preauthorization request, Anthem will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

Retrospective Appeal. If your Appeal relates to a retrospective claim, Anthem will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee) and where appropriate your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment; home health care services following discharge from an inpatient Hospital admission; services in which a Provider requests an immediate review; or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If you are not satisfied with the resolution of your expedited Appeal, you may file a standard internal Appeal or an external review.

Substance Use Appeal. If Anthem denies a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your Provider file an expedited internal Appeal of the adverse determination, Anthem will decide the Appeal within 24 hours of receipt of the Appeal request. If you or your Provider file the expedited internal Appeal and an expedited external review within 24 hours of receipt of Anthem's adverse determination, Anthem will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external review is pending.

I. Second Level Appeal. If you disagree with the first level Appeal determination, you or your designee can file a second level Appeal. You or your designee can also file an external review. The four month timeframe for filing an external review begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for you to file for external review.

A second level Appeal must be filed within 60 days of receipt of the final adverse determination on the first level Appeal. Anthem will acknowledge your request for an internal Appeal within 15 calendar days of receipt and will include the name, address, and phone number of the person handling your Appeal and inform you, if necessary, of any additional information needed before a decision can be made.

Preauthorization Appeal. If your Appeal relates to a Preauthorization request, Anthem will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to

you (or your designee), and where appropriate, your Provider, within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

Retrospective Appeal. If your Appeal relates to a retrospective claim, Anthem will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your Provider, within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

External Appeal

If the outcome of your appeal is adverse to you, and it was based on medical judgment, pertained to a rescission of coverage, a determination that care was experimental or investigational, or involved consideration of whether the Plan complied with the surprise billing or cost-sharing protections of the No Surprises Act, you may be eligible for an independent External Review pursuant to federal law.

You must exhaust all internal appeals prior to requesting external review. You or your authorized representative must submit your request for External Review in writing to Anthem within four months of the receipt of your final internal adverse benefit determination. Within five business days following the date of receipt of the External Review request, a preliminary review of the request will be performed to determine whether:

- You are (or were) covered under the Plan at the time the healthcare item or service was requested, or in the case of a retrospective review, you were covered under the Plan at the time the healthcare item or service was provided;
- The adverse benefit determination is not based on the fact that you were not eligible for coverage under the Plan;
- You have exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
- You have provided all the information required to process an external review.

You will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request and set forth the time limit for you to provide the additional information needed (the longer of the initial four month period within which to request an external review or, if later, 48 hours [or such longer period specifically identified in the notice] after the receipt of the notice). If the claim is eligible for External Review, an Independent Review Organization will be assigned to conduct the External Review.

For Pre-Service Claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. To proceed with an Expedited External Review, you, a Provider, or your authorized representative may request it orally or in writing to:

Grievance and Appeals
PO Box 1407
Church Street Station
New York, NY 10008-1407

For an Expedited External Review, the preliminary review described above will be performed immediately. If the claim is eligible for External Review, an Independent Review Organization will be assigned to conduct the External Review.

All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, fax, or other similar method. To proceed with an Expedited External Review, you, your provider, or your authorized representative must provide at least the following information:

- Participant's name and ID number;
- Date(s) of the medical service;
- Specific medical condition or symptom;
- Provider's name;
- Service or supply for which approval of benefits was sought; and
- Any reasons why the Appeal should be processed on a more expedited basis.

Requesting External Review is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under the Plan. There is no charge for you to initiate an independent External Review. However, the External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Coordination Of Benefits

Coordination of Benefits applies when you have health coverage with another plan. When you receive a Covered service, Anthem will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary. This coordination

prevents duplicate payments and overpayments.

A. Definitions

Allowable expense is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

Plan is other group health coverage with which the Benefits Fund will coordinate benefits. The term "plan" includes:

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premium or Fees.
- Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

Primary plan is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

- The plan has no order of benefits rules or its rules differ from those required by regulation; or
- All plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first.

Secondary plan is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decides the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment

The first of the rules listed below that applies will determine which plan will be primary.

1. If the plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving the benefits is the Subscriber and is only covered as a dependent under the other plan, this Plan will be primary. If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the child will receive primary coverage from the parent whose birthday occurs earlier in a calendar year. If both parents have the same birthday, the plan that has covered the parent the longest is primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are divorced or separated, and there is no court decree stating that one parent is responsible for the child's health care expenses:

- The plan of the parent with custody will be primary;
- If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent without custody will pay third; or
- If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination. When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed this Plan's maximum available benefit for each Covered Service. Also, the amount Anthem pays will not be more than the amount it would pay if it were primary. As each claim is submitted, Anthem will determine its obligation to pay for allowable expenses based upon all claims that have been submitted

up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information. Anthem may release or receive information that it needs to coordinate benefits. Anthem does not need to tell anyone or receive consent to do this and is not responsible to anyone for releasing or obtaining this information. You must give Anthem any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment. If Anthem made a payment as a primary plan, you agree to pay Anthem any amount by which Anthem should have reduced its payment. Also, Anthem may recover any overpayment from the primary plan or the Provider receiving payment and you agree to sign all documents necessary to help Anthem recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans. Anthem will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Plan is primary, as defined in this section, Anthem will pay benefits first.
- If this Plan is secondary, as defined in this section, Anthem will pay only the amount it would pay as the secondary insurer.
- If Anthem requests information from a non-complying plan and does not receive it within 30 days, it will calculate the amount it should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, Anthem will make any necessary adjustments.

G. When a Covered Person Qualifies for Medicare. 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 as follows:

- 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; or
- 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.

Subrogation And Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source.

A. Recovery. A "Recovery" includes, but is not limited to, monies received from any person or party; any person's or party's liability insurance; uninsured/underinsured motorist proceeds; worker's compensation insurance or fund "no-fault" insurance; and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

B. Subrogation. The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated and regardless of whether the payments you receive make you whole for your losses, illnesses, and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall

be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses, or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses, or costs you incur. The ''common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

C. Reimbursement. If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses, and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses, or costs. The ''common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
    1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
    2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement, or underlying claim for damages or fully compensate you or make you whole.

D. Your Duties. You must promptly notify the Plan of how, when, and where an accident or incident resulting in personal injury or illness to you occurred; all information regarding the parties involved; and any other information requested by the Plan.

- You must cooperate with the Plan in the investigation, settlement, and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices, or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is

commenced, if a settlement occurs, or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

General Provisions

1. Agreements Between Anthem and Participating Providers. Any agreement between Anthem and Participating Providers may only be terminated by Anthem or the Providers. This Plan does not require any Provider to accept a participant as a patient. Anthem does not guarantee a participant's admission to any Participating Provider or any health benefits program.

2. Clerical Error. Clerical error, whether by the Benefits Fund or Anthem, with respect to this Plan, or any other documentation issued by Anthem in connection with this Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

3. Conformity with Law. Any term of this Plan that is in conflict with any applicable federal law will be amended to conform with the minimum requirements of such law.

4. Continuation of Benefit Limitations. Some of the benefits of this Plan may be limited to a specific number of visits and/or subject to a Deductible. You will not be entitled to any additional benefits if your coverage status should change during the year. For example, if your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

5. Enrollment ERISA. The Benefits Fund will develop and maintain complete and accurate eligibility records, as well as any other records of the names, addresses, ages, and social security numbers of all participants covered under this Plan, and any other information required to confirm their eligibility for coverage.

The Fund will provide Anthem with this information upon request. The Fund may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Fund. Anthem is not the ERISA plan administrator.

The Fund will provide Anthem with the enrollment information including your name, address, age, and social security number and advise Anthem when you are to be added to or subtracted from Anthem's list of covered persons.

6. Fraud and Abusive Billing. Anthem has processes to review claims before and after payment to detect fraud and abusive billing.

Participants seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

7. Furnishing Information and Audit. The Benefits Fund and all persons covered under this Plan will promptly furnish Anthem with all information and records that it requires from time to time to perform its obligations under this Plan. You must provide Anthem with information over the telephone for reasons such as the following:

- To allow Anthem to determine the level of care you need;
- So that Anthem may certify care authorized by your Physician; or
- To make decisions regarding the Medical Necessity of your care.

The Benefits Fund will, upon reasonable notice, make available to Anthem, and Anthem may audit and make copies of, any and all records relating to Benefits Fund enrollment.

8. Identification Cards. Identification cards are issued by Anthem for identification purposes only. Possession of any ID card confers no right to services or benefits under this Plan. To be entitled to such services or benefits, contributions must be paid in full.

9. Incontestability. No statement made by you will be the basis for avoiding or reducing coverage unless it is in

writing and signed by you. All statements contained in any such written instrument shall be deemed representations and not warranties

10. Independent Contractors. Participating Providers are independent contractors. They are not Anthem agents or employees. Anthem and its employees are not the agent or employee of any Participating Provider. Anthem is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by you, your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

11. Material Accessibility. Anthem will provide you with ID cards, while the Fund will provide you with an SPD and other necessary materials regarding this Plan.

12. Recovery of Overpayments. On occasion a payment may be made to you when you are not covered, for a service that is not Covered, or which is more than is proper. When this happens, Anthem will explain the problem to you and you must return the amount of the overpayment to Anthem within 60 days after receiving notification from them.

13. Right to Develop Guidelines and Administrative Rules. Anthem may develop or adopt standards that describe in more detail when it will or will not make payments under this Plan. Examples of the use of the standards are to determine whether Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat your illness or injury; or if certain services are skilled care. Those standards will not be contrary to the descriptions in this SPD. If you have a question about the standards that apply to a particular benefit, you may contact Anthem for an explanation of the standards. Anthem shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the administration of this Plan.

14. Right to Offset. If Anthem makes a claim payment to you or on your behalf in error or you owe Anthem any money, you must repay the amount you owe. Except as otherwise required by law, if Anthem owes you a payment for other claims received, it has the right to subtract any amount you owe Anthem from any payment it owes you.

15. Service Marks. Anthem is an independent corporation organized under the New York Insurance Law. Anthem also operates under licenses with the Blue Cross and Blue Shield Association, which licenses Anthem to use the Blue Cross and/or Blue Shield service marks in a portion of New York State. Anthem does not act as an agent of the Blue Cross and Blue Shield Association. Anthem is solely responsible for the obligations created under this agreement.

16. Severability. The unenforceability or invalidity of any provision of this Plan shall not affect the validity and enforceability of the remainder of this Plan.

17. Significant Change in Circumstances. If Anthem is unable to arrange for Covered Services as provided under this Plan as the result of events outside of its control, Anthem will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. Anthem will make reasonable attempts to arrange for Covered Services. Anthem and its Participating Providers will not be liable for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

18. Third Party Beneficiaries. No third-party beneficiaries are intended to be created by this Plan and nothing in this Plan shall confer upon any person or entity other than you or Anthem any right, benefit, or remedy of any nature whatsoever under or by reason of this Plan. No other party can enforce this Plan's provisions or seek any remedy arising out of either our or your performance or failure to perform any portion of this Plan, or to bring an action or pursuit for the breach of any terms of this Plan.

19. Time to Sue. You may bring a civil action in federal court under Section 502(a) of ERISA.

20. Venue for Legal Action. If a dispute arises under this Plan, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Anthem in a court anywhere else. You also consent to New York State courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order you to defend any action Anthem brings against you.

21. Waiver. The waiver by any party of any breach of any provision of this Plan will not be construed as a waiver of any subsequent breach of the same or any other provi-

sion. The failure to exercise any right hereunder will not operate as a waiver of such right.

22. Who May Change This Plan. This Plan may not be modified, amended, or changed, except in writing and signed by the Benefits Fund Trustees or a person designated by the Trustees. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Plan in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation unless in writing and signed by the Trustees or person designated by the Trustees.

23. Who Receives Payment Under This Plan. Payments under this Plan for services provided by a Participating Provider will be made directly by Anthem to the Provider. If you receive services from a Non-Participating Provider, Anthem reserves the right to pay either You or the Provider. See the "How Your Coverage Works" section of this chapter (Page 32) for more information about surprise bills.

24. Workers' Compensation Not Affected. Coverage provided under the Plan is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

25. Your Medical Records and Reports. In order to provide your coverage under this Plan, it may be necessary for Anthem to obtain your medical records and information from Providers who treated you. Anthem's actions to provide that coverage include processing your claims, reviewing Grievances, Appeals, or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Plan, you automatically give Anthem or its designee permission to obtain and use your medical records for those purposes and you authorize every Provider who renders services to you to:

- Disclose all facts pertaining to your care, treatment, and physical condition to Anthem or to a medical, dental, or mental health professional that Anthem may engage to assist it in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to your care, treatment, and physical condition to Anthem, or to a medical, dental, or mental health professional that Anthem may engage to assist it in reviewing a treatment or claim; and
- Permit copying of your medical records by Anthem.

Anthem agrees to maintain your medical information in accordance with state and federal confidentiality requirements. However, you automatically give Anthem permission to share your information with the New York State Department of Health, quality oversight organizations, and third parties with which Anthem contracts to assist in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

26. Your Rights. As a participant, you have certain rights and responsibilities when receiving your healthcare. As a healthcare partner, Anthem wants to make sure your rights are respected while providing your health benefits. This also means giving you access to Participating Providers and the information you need to make the best decisions for your health and welfare.

- You have the right to obtain complete and current information concerning a diagnosis, treatment, and prognosis from a Physician or other Provider in terms you can reasonably understand. When it is not advisable to give such information to you, the information shall be made available to an appropriate person acting on your behalf.
- You have the right to receive information from your Physician or other Provider that you need in order to give your informed consent prior to the start of any procedure or treatment.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- You have the right to formulate advance directives regarding your care.
- You have the right to access Anthem's Participating Providers.

As a participant, you should also take an active role in your care. Anthem encourages you to:

- Understand your health problems as well as you can and work with your Providers to make a treatment plan that you all agree on;
- Follow the treatment plan that you have agreed on with your doctors or Providers;
- Give Anthem, your doctors, and other Providers the information needed to help you get the care you need and all the benefits you are eligible for under this Plan. This may include information about other health insurance benefits you have along with your coverage with the Fund; and
- Inform the Fund if you have any changes to your name, address or Dependents covered under your Plan

Definitions

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 chapter, 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.

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit and includes a Rescission of Coverage, whether or not there is an adverse effect on any particular benefit.

Allowed Amounts – The maximum amount on which Anthem's payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this chapter for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount you will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center – 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.

Ancillary Services – With respect to a Participating health care facility, services include:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Appeal – A request for Anthem to review a Utilization Review decision or a Grievance again.

Balance Billing – When a Non-Participating Provider bills you for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill you for Covered Services.

Calendar Year – A period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

Claims Administrator – Anthem BlueCross BlueShield was chosen by the Fund to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance – Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that you are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment (or Copay) – A fixed amount you are required to pay directly to a Provider for certain Covered Services when you receive the service. The amount can vary by the type of Covered Service.

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 Anthem 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.

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.

Dependent – The Subscriber's Spouse and Children.

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

- Primarily and customarily used to serve a medical purpose;
- Generally not of use to a person in the absence of a disease or injury;
- Designed and intended for repeated use;
- Appropriate for use within the home.

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 Condition – 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.

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

Emergency Services – A medical screening examination that is within the capability of the emergency department of a Hospital, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital/Facility, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Hospital/Facility, or to deliver a newborn child (including the placenta).

For purposes of the No Surprises Act, Emergency Services furnished by a Non-Participating Provider or Non-Participating emergency Facility (regardless of the department of the Hospital/Facility in which such items or services are furnished) also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Condition, until:

- The Provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and
- You are supplied with a written notice, as required by federal law, that the Provider is a Non-Participating Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Participating Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Participating Providers listed; and
- You give informed consent to continued treatment by Non-Participating Provider, acknowledging that you understand that continued treatment by the Non-Participating Provider may result in greater cost to you.

Exclusions – Health care services the Plan does not pay for or Cover.

Facility – A Hospital, Ambulatory Surgical Center, birthing center, dialysis center, rehabilitation Facility, Skilled Nursing Facility, hospice, Home Health Agency, or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If you receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance – A complaint that you communicate to Anthem that does not involve a Utilization Review determination.

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; nurse practitioner; or any other licensed, registered, or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law 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 currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

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 pursuant to New York Public Health Law Article 40 or under a similar certification process 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 un-

der 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;
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- 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 rehabilitory 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.

Medically Necessary – See the "How Your Coverage Works" section of this chapter on Page 32.

Medicare – Title XVIII, United States Social Security Act, as amended.

Member – The Subscriber or a covered Dependent for whom required fees have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Network – The Providers Anthem has contracted with to provide health care services to you.

Non-Participating Provider – A Provider who doesn't have an agreement or a contract with Anthem or another Blue Cross and/or Blue Shield plan to provide health care services to you. You will pay more to see a Non-Participating Provider.

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-Pocket Limit – The most you pay in Cost-Sharing before the Plan begins to pay 100 percent of the In-Network contracted amount for Covered Services. This limit never includes 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 Anthem or another Blue Cross and/or Blue Shield plan to provide health care 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 Anthem 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 A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician – A Participating 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 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 law.

Recognized Amount – The amount determined pursuant to 29 C.F.R 2590.716-3.

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.

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.

Serious and Complex Condition – Includes one of the following:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that is the following:
    1. Life threatening, degenerative, potentially disabling, or congenital; and
    2. Requires specialized medical care over a prolonged period of time.

Service Area – The geographical area, designated by Anthem and approved by the State of New York in which Anthem provides coverage. Anthem's Service Area consists of the following 28 counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester.

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 Anthem 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.

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

Subscriber – The person to whom this SPD is issued.

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 a Physician's office or Urgent Care Center. For purposes of the No Surprises Act, an Urgent Care Center licensed to provide Emergency Services is considered a freestanding emergency facility when it provides Emergency Services subject to the No Surprises Act.

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).

It's important you are treated fairly

That's why Anthem follows federal civil rights laws in our health programs and activities. Anthem doesn't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, gender, age, or disability. For people with disabilities, Anthem offers free aids and services. For people whose primary language isn't English, Anthem offers free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think Anthem has failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with Anthem's Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling (800) 1019 (TDD: (800) 537-7697) or online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**. Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

Federal 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 ser-

vices (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].

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, employer health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits Medical Necessity criteria available upon request.

Federal Patient Protection and Affordable Care Act Patient Protection Notices

Anthem generally allows the designation of a Primary Care Physician. You have the right to designate any Primary Care Provider who participates in Anthem'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 Participating 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 Anthem 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 Anthem'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 Participating health care professionals specializing in obstetrics or gynecology, call the Benefits Fund at (877) RN BENEFITS [762-3633].

Chapter 10: Prescription Drug Benefits

The Benefits Fund contracts with 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 website at **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). 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 (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 (90 day supply)

Tier 1: $15/generic
Tier 2: $40/preferred brand
Tier 3: $70/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.

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 40512-4711or 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 website at **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.

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 **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 website at **rnbenefits.org** or Express Scripts' website at **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' website at **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, sanitorium, extended care facility, or convalescent home (may be covered under medical services);
- Any charge for the administration of prescription legend drugs or injectable insulin;
- Immunization agents, biological sera, blood, or blood plasma (may be covered under medical services);
- Any medication, legend or not, which is consumed or administered at the place where it is dispensed (may be covered under medical services);
- Refilling a prescription in excess of the number specified by the physician or dentist, or any refill dispensed following one year of the physician's or dentist's order;
- Refills on a prescription (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;
- Reimbursement for drugs obtained via discounted pricing or coupons through the manufacturer or pharmacy; 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)
- Growth hormones (stimulates growth, cell reproduction, cell regeneration)
- Inflammatory conditions (immune disorders causing the immune system to attack certain areas/organs in the body).

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

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

Participants are prompted to try a generic drug or a select preferred drug within the same drug class. The generic may not be a direct generic equivalent of the prescribed medication. However, participants may progress to other brand-name drugs after trying the required generic or select preferred brand drug. If your doctor believes the prescribed brand-name drug is medically necessary, he can call 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 utilization 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); or
- 15 days for non-urgent claims.

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

Prior uuthorization 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 website at **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); or
- 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 86 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 on Aetna's website at **aetna.com** or by calling the Fund office 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; or
- 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 email 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 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 91.)

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 website at **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 services 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; or
- 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 require 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. Knowing ahead of time which services are eligible dental services and what your plan may pay helps you and your dentist make informed decisions about the care you are considering. It is not a guarantee of benefit payment, rather an estimate of the amount or scope of benefits to be paid.

In estimating the amount of benefits payable, Aetna will look at alternate procedures, services, or courses of treatment for the dental condition in question in order to meet the expected result. 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.

The estimate is voluntary. It is not necessary for dental emergency services or routine care such as cleaning teeth or check-ups or any other service.

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Here are the steps involved with getting an advance claim review:

1. Ask your dentist to write down a full description of the treatment you need. They must either use an Aetna claim form or an American Dental Association (ADA) approved claim form.
2. Your dentist should send the form to Aetna before treating you.
3. Aetna may request supporting images and other diagnostic records.
4. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the estimated benefits payable.
5. 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

Eligible dental services include dental services provided for a dental emergency. The care provided must be a covered benefit.

If you have a dental emergency, you should consider calling your network dental provider who may be more familiar with your dental needs. However, you can get treatment from any dentist including one that is an out-of-network provider. If you need help in finding a dentist, call the Benefits Fund at (877) RN BENEFITS [762-3633].

If you get treatment from an out-of-network provider for a dental emergency, the plan pays a benefit at the network cost-sharing level of coverage.

For follow-up care to treat the dental emergency, you should consider using your network dental provider so that you can get the maximum level of benefits. Follow-up care will be paid at the cost-sharing level that applies to the type of provider that gives you the care.

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 clinically 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 exams

- Oral examination (limited to two visits per calendar year
- Prophylaxis and/or periodontal maintenance are limited to two treatments per calendar year
- Periapical images
- Intra-oral, occlusal view
- Extra-oral
- Topical application of fluoride (limited to one course of treatment per year for dependent children through age 18.
- Sealants limited to once per tooth every three years for permanent molars only for children to age 18.

Images and pathology

- Bitewing X-rays (limited to two sets per calendar year)
- Entire 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)

Type B expenses (basic restorative care)

Visits and exams

- Office visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit.
- Images and pathology
- Accession of tissue

Oral surgery

- Extractions – coronal remnants – deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth
    - Soft tissue
    - Partially bony
    - Completely bony
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue

- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Coronectomy

Periodontics

- 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)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplast, four or more per quadrant
- Gingivectomy/gingivoplasty, one to three teeth per quadrant
- Gingival flap procedure, including root planing, four or more per quadrant
- Gingival flap procedure, including root planing, one to three teeth per quadrant
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating dentist or their staff)
- 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
- Distal wedge procedure

Endodontics

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

***Restorative* - Excluding inlays, onlays and crowns. Multiple restorations in one surface will be considered as a single restoration.**

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Protective restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Interim therapeutic restoration – primary dentition
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (excluding temporary crowns)
- Recementation
- Occlusal guard for bruxism (one every three years)
- Repairs – inlay, onlay, veneer, crown
- Repairs, full
- Repairs, partial denture
- Repairs, bridges
- Adding teeth and clasps to existing partial denture
- Adjustments, repair or reline of occlusal guard

General anesthesia and intravenous sedation

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure and clinically necessary
- Evaluation by anesthesiologist for deep sedation or general anesthesia

Space maintainers (Only when needed to preserve space resulting from premature loss of primary teeth; includes all adjustments within six months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removable (unilateral or bilateral)

Type C expenses (major restorative care)

Restorative (Inlays, onlays, labial veneers, and crowns (excludes temporary 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
- Crowns
- Post and core

Prosthodontics

The first installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than five years old. (See the Tooth missing but not

replaced rule.) Replacement of existing bridges or dentures is limited to one every five years. (See the Replacement rule.)

- Bridge abutments
- 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 and lower denture
  - Partial upper and lower (including any conventional clasps, rests and teeth)
  - Removable unilateral partial dentur
  - Stress breaker
  - Interim partial denture (stayplate), anterior only
  - reline (partial or complete)
  - Special tissue conditioning, per dentur
  - Rebase, per denture
  - Adjustment to denture more than six months after installation
  - Cleaning and inspection of a removable appliance

Orthodontics

- Limited orthodontic treatment
- Comprehensive orthodontic treatment of adolescent dentition
- Comprehensive orthodontic treatment of adult dentition
- Orthodontic retention

Repair of orthodontic appliance

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.

Orthodontic treatment rule

Orthodontic treatment is covered on the date active orthodontic treatment begins.

This benefit does not cover charges for the following:

- 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”)

The above list of covered services is subject to change.

Orthodontic limitation for late enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the two year period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.

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. If a charge is made for a non-eligible dental service or supply and an eligible dental service that would provide an acceptable result, then your plan will pay a benefit for the eligible dental service or supply. If a charge is made for an eligible dental service but another eligible dental service that would provide an acceptable result is less expensive, the benefit will be for the least expensive eligible dental service. The benefit will be based on the network provider’s negotiated charge for the eligible dental service or, in the case of an out-of-network provider, on the recognized charge.

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

Some eligible dental services are subject to your plan’s re-

placement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These eligible dental services are covered only when you give Aetna proof 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 item cannot be made serviceable, and is:

- A crown installed at least five years before its replacement.
- An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, alternate treatment rule applies, or other prosthetic item installed at least five years before its replacement.
- While you were covered by the plan:
  - You had a tooth (or teeth) extracted.
  - our 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 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 or completed after your coverage terminates.

Claim decisions and appeals procedure

Claim determinations

Claims are processed in the order in which they are received Aenta will review your claim for payment to the provider or to you as appropriate.

- A description of services
- Bill of charges

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.

Adverse benefit determinations

Aetna pays many claims at the full rate negotiated charge with network providers and the recognized charge with out-of-network providers. But sometimes Aetna may pay only some of the claim, and sometimes Aetna won't pay at all. Any time Aetna doesn't pay even part of the claim that is an "adverse benefit determination" or "adverse decision".

If Aetna makes an adverse benefit determination, Aetna will tell you in writing.

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.
- 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 in writing. 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.
- 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.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 24 months after the deadline.

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. In addition, some services are specifically limited or excluded. This section describes expenses that aren't covered or subject to special limitations.

Coverage isn't provided for the following services/supplies

- Provided by network providers in excess of the negotiated charge
- Provided by an out-of-network provider in excess of the recognized charge
- Provided for your personal comfort or convenience, or the convenience of any other person, including a dental provider
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
  - Care in charitable institutions

- Care for conditions related to current or previous military service
- Care while in the custody of a governmental authority

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the Eligible Dental Services section of the schedule of benefits)

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 and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons
- Facings on molar crowns and pontics will always be considered cosmetic

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.

Dental services and supplies

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- 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 you were not covered
  - General anesthesia and intravenous sedation, unless specifically covered and done in connection with another eligible dental service
- Instruction for diet, tobacco counseling and oral hygiene
- Orthodontic treatment except as covered in the Eligible Dental Services section of the schedule of benefits
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the Eligible Dental Services section of the schedule of benefits
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
- Temporomandibular joint dysfunction/disorder

Dental services and supplies that are covered in whole or in part:

- Under any other plan of group benefits provided by the Customer
- Experimental or investigational
- Experimental or investigational drugs, devices, treatments or procedures

Non-medically necessary services

- 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.

Other primary payer

- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals

- Treatment by 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 are:
  - Scaling of teeth
  - Cleaning of teeth
  - Topical application of fluoride.
  - Charges submitted for services by an unlicensed provider or not within the scope of the provider's license.

Services paid under your medical plan

- Your plan will not pay for amounts that were paid for the same services under a medical plan covering you. When a dental service is covered under both plans, we will figure the amount that would be payable under this plan if you did not have other coverage, then subtract what was paid by your medical plan. If there is any difference, this plan will pay it. If the amount paid by your medical plan is equal to or more than the benefit under this plan, this plan will not pay anything for the service.

Services provided by a family member

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "not work related" 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 myofacial pain dysfunction; or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

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

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

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

Negotiated charge – The maximum charge a preferred care provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Network provider – A dental provider who has contracted to furnish services or supplies for a negotiated charge but only if the provider is, with Aetna's consent, included in the directory as a network provider for the service or supply involved and the class of employees to which you belong.

Nonoccupational illness – An illness that does not arise out of (or in the course of) any work for pay or profit or result in any way from an illness that does. An illness will be deemed to be nonoccupational regardless of cause if proof is furnished that the person is covered under any type of workers' compensation law and is not covered for that illness under such law.

Nonoccupational injury – An accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury which does.

Occupational injury/illness – An injury or illness that arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full-time basis, or results in any way from an injury or illness which does.

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 (when using a Davis Vision provider dependent children up to age 18 are eligible for an exam 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 receive the greatest value by staying in-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 go to Davis Vision's website at **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 is available by calling call the Fund office 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 **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. You may select a Premier level frame from the Davis Collection for an additional $20 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 from Davis Vision's Contact Lens Collection (including evaluation, fitting, and follow-up). If lenses are disposable, the plan covers two to four boxes/multi-packs depending on the covered lens. 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:

- $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 website at **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 provider 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 phone 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. See Page 6 in Chapter 1 of this SPD regarding the process for filing such an appeal.

Chapter 13: Paid Family Leave

The NYSNA Benefits Fund has contracted with MetLife 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 MetLife at (800) 504-7877. 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, siblings, 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, siblings, 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 of 12-weeks of paid leave with a capped percentage of 67 percent of the NYS Average Weekly Wage during any given 52-week period. The 52-week period starts on the first day the participant takes PFL.

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 States 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.
- Your claim for Short-Term Disability should be filed before initiating your Paid Family Leave claim. 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. You cannot be paid Short-Term Disability and Paid Family Leave benefits simultaneously.
- Paid Family Leave cannot be used in conjunction with Short Term Disability. 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.

Filing a claim

To file a claim for Paid Family Leave, contact MetLife at (800) 504-7877, Monday through Friday, 8 a.m. to 11 p.m. EST. You should identify yourself as a NYSNA Benefits Fund participant and provide your legal name. Before calling to file a claim be prepared with specific dates for the start of your Paid Family Leave period and whether your time will be intermittent or continuous.

Claims need to be filed within 30 days of leave; if not, all or a portion of the leave could be denied. Denied claims can be appealed.

Chapter 14: Short Term Disability

The Benefits Fund has contracted with MetLife 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 66 $^{2/3}$ % 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.

Short-term disability benefits for childbirth must be used before Paid Family Leave for child bonding. You cannot take more than 26 weeks of combined short-term disability and Paid Family Leave 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 website at **rnbenefits.org,** or at your place of employment.

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

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

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

Appealing a denied claim

If your short-term weekly disability claim is denied, you'll receive a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451) that will explain all necessary instructions for appealing your denied claim.
You have up to 26 weeks to appeal the adverse benefit determination. Following denial of a claim:

- The claimant will have access, upon request, to all relevant information, including the claimant's entire claim file, materials identifying any medical or vocational expert whose advice was used in making the benefit determination, and any other

documents that reflect the plan's general policy regarding the claim.

- The plan cannot impose fees or costs as a condition to filing or appealing a claim.
- Arbitration is permitted, but only with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if the claimant agrees after completing internal appeal.
- Review must be de novo (new). The decision-maker on an appealed claim must be different from (and not subordinate to) the person deciding the initial claim. The claimant also must have the opportunity to submit new evidence.
- The plan must consult with appropriate health care professionals in deciding appealed claims involving medical judgment.
- The plan may not require more than two levels of review of denied claims (if there's more than one level, both levels must be completed within the time frame applicable to one level).

The plan must have procedures and safeguards for ensuring and verifying consistent decision-making.

If the plan fails to make timely decisions or otherwise fails to comply with the regulation, claimants may go to court to enforce their rights.

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

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

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

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

Chapter 16: Life Insurance Benefits

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

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

If you become totally disabled

If you become totally disabled before your 60th birthday, your life insurance coverage will be continued during your disability, up to your normal retirement date, at no cost. Coverage will continue as long as you submit annual proof of disability to The Benefits Fund.

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 MetLife

Your benefit may be payable before approval of waiver 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. MetLife 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.

MetLife 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 MetLife 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 MetLife 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 MetLife for the required premiums.

Accelerated Benefit Option (ABO)

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 $20,000 MetLife will pay you the accelerated benefit in a lump sum amount, provided MetLife receives proof of the terminal illness.

The accelerated benefit option 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. 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 $50,000 and are terminally ill, you can request any portion of the amount of life insurance benefits from $20,000 to $40,000 to be paid now instead of to your beneficiary upon death. 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 taxable. 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, as well as an original death certificate. Send the letter and document to the NYSNA Benefits Fund, PO Box 12430, Albany, NY 12212-2430.

The initial decision on a life insurance claim will be made within 90 days. This 90-day period will begin at the time the claim is received by the claims administrator, without regard to whether all the information necessary to make a benefit determination has been provided with the claim request. If the claims administrator determines that special circumstances require an extension of time for processing the claim, you will be notified before the end of the initial 90-day period of the need for a 90-day extension. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the claims administrator expects to make a determination.

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 MetLife 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 MetLife 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.

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 7 of this book for the rules governing your COBRA continuation coverage rights.

Prudent actions by plan fiduciaries

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

Enforce your rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $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 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 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 MetLife (life insurance, short-term disability, and paid family leave benefits) and Davis Vision (vision benefit). Other benefits, including medical, dental, and prescription drug coverage are self-insured by the Fund and the Fund pays administrative fees to Anthem Blue-Cross BlueShield, Aetna, 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

You may bring a civil action in federal court under Section 502(a) of ERISA. 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 Chapters 1 and 3 of this book.