

**NEW YORK STATE NURSES ASSOCIATION
WELFARE FUND FOR NEW YORK CITY
EMPLOYED REGISTERED PROFESSIONAL NURSES**
Plan Directory

Trustees

Anne Bové, RN
Judith Cutchin, RN
Nancy D'Leema, RN
Doreen Gatanas, RN
Keyshia Morris, RN

Plan Administrator

John J. Barrett
c/o New York State Nurses Association
155 Washington Ave
Albany, NY 12210

Plan Claims Administrator

Administrative Services Only, Inc. (ASO)
303 Merrick Rd. , Suite 300
Lynbrook, NY 11563

Plan Counsel

Larry Magarik, Esq.
113 University Place, 7th Floor
New York, NY 10003-4527

To obtain a claim form (other than dental) or additional
information about plan benefits, contact:

ADMINISTRATIVE SERVICES ONLY INC.

Toll Free: 1-888-692-7671

Web Site: www.asonet.com

To obtain claim forms and make claim inquiries for
the dental benefit plan, contact:

Aetna

P.O. Box 14094

Lexington, KY 40512

1-877-238-6200

Web Site: www.aetna.com

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INTRODUCTION

Dear Participant:

This is the revised and updated Plan Document and Summary Plan Description (together referred to as (SPD) which describes the benefits available to you through the New York State Nurses Association Welfare Fund for New York City Employed Registered Professional Nurses ("the Fund" or "the Plan").

The Plan is an employee benefit trust fund, financed by contributions fixed by Collective Bargaining or other written agreements, and administered by a Board of Trustees designated by the New York State Nurses Association (NYSNA) pursuant to an Agreement and Declaration of Trust (Trust Agreement) which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted the Plan of benefits described in this SPD. Under the Trust Agreement and this SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and this SPD, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees, whose determinations are final and binding.

The Plan is currently funded by public employers such as the New York City Health and Hospitals Corporation (HHC) and the City of New York. The Plan receives its funds pursuant to the terms of the contracts negotiated by the New York State Nurses Association on your behalf. The contracts require your employer to make contributions to the Plan.

This SPD describes the benefits, eligibility guidelines, rules and regulations and the procedures to follow to obtain benefits and information. We urge you to read this document carefully, as there have been changes and improvements in your benefits, and keep it handy for future reference.

Although the Plan is not technically covered by the Employee Retirement Income Security Act (ERISA), the Trustees have elected to apply the rules and standards applicable under ERISA and under other law. The Board of Trustees reserves the right to change or discontinue the Plan and/or these benefits, in whole or in part, at any time and for any reason.

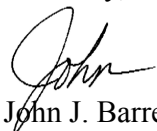
The Plan provides benefits that are supplemental to the basic benefits provided by the City of New York's base plan. Your coverage under the base plan is outlined in the New York City Employee Benefits Program Summary Program Description. The Plan is funded by contributions from the City of New York under the NYSNA collective bargaining agreement. On a continuing basis, the Board of Trustees of the Plan carefully evaluates health and welfare insurance programs and other benefits in an effort to bring you the most comprehensive benefit program possible. A major priority of the trustees is to provide protection to participants against common recurring health problems and insure maximum access to and utilization of plan benefits to the maximum extent possible within the Plan's resources, benefit coverage is also provided for participant's dependents.

The Board of Trustees is appointed by the New York State Nurses Association and serves without compensation. Trustees are responsible for insuring that plan operations, expenditures and reserves are consistent with the requirements of the City's Directive 12 and other applicable law and regulation.

While the Trustees expect the Plan to continue, they reserve the right to change or discontinue the Plan and/or these benefits, in whole or in part, at any time and for any reason.

Information herein describes plan benefits and the procedures to be followed to insure prompt and efficient handling of your claims. Should you desire additional information or have any questions, please contact the Plan's contract administrators, Administrative Services Only, Inc. or the NYSNA program who services your facility at the NYSNA New York City office 212-785-0157. In addition, the trustees and I would welcome any comment or suggestions you wish to offer regarding the Plan.

Cordially,



John J. Barrett
Plan Administrator

GENERAL INFORMATION

Name of Plan: New York State Nurses Association Welfare Fund for New York City Employed Registered Professional Nurses

Plan Sponsor: Board of Trustees, New York State Nurses Association Welfare Fund for New York City Employed Registered Professional Nurses

Employer Identification No.: 23-7444482

Named Fiduciaries/Trustees:

Anne Bové, RN
Bellevue Hospital Center
462 First Avenue & 2nd Street
New York, NY 10016

Judith Cutchin, RN
Woodhull Hospital
760 Broadway
Brooklyn, NY 11206

Nancy D'Leema, RN
Lincoln Medical and Mental Health Center
234 Eugenio Maria De Hostos Blvd
(East 149th St)
Bronx, NY 10451

Doreen Gatanas, RN
Elmhurst Hospital
79-01 Broadway
Elmhurst, NY 11373

Keyshia Morris, RN
Department of Corrections,
City of New York
One Lefrak Plaza, 14th Fl
Corona, NY 11368

Plan Administrator: John J. Barrett, Director of Finance
New York State Nurses Association
155 Washington Ave
Albany, NY 12210
(518) 782-9400

NYSNA Metropolitan New York Office
131 West 33rd Street, 4th Floor
New York, NY 10001
(888) 551-3112 (toll-free)

Claims Administrator: Sue Guisti, Client Manager
Administrative Services Only
303 Merrick Rd, *or*
PO Box 9005
Lynbrook, NY 11563
(888) 692-7671
fax - (877) 389-6785
sueguisti@asonet.com

Type of Plan: Welfare Plan

Nature of Administration: The Plan is partially self-insured and also offers insurance which is administered through:

Aetna Dental
100 Park Avenue, 7th Floor
New York, NY 10017
(203) 878-6413

OptumRx Prescriptions
PO Box 9472
Minneapolis, MN 55440
1-888-691-0130

Life Insurance
The Hartford
200 Hopmeadow St
Simsbury, CT 06089
*Benefit is administered by:
Administrative Services Only, Inc.*

Other Self Insured Claims
Administrative Services Only, Inc.
303 Merrick Rd
Lynbrook, NY 11563
1-888-692-7671

Source of Contributions
to the Plan:

The Plan is funded by contributions paid by Contributing Employers of Eligible Employees of the Contributing Employers who are participants in or beneficiaries of the Plan.

Effective Date:

September 26, 1969

Plan Year:

July 1 - June 30

Agent for Service of
Legal Process:

The designated agent for service of legal process upon the Plan is, and service of legal process may be made upon:

John J. Barrett, Director of Finance
New York State Nurses Association
155 Washington Ave
Albany, NY 12210

Amendment to the Plan:

The Board of Trustees may amend the Plan, in whole or in any part, at any time.

**NYSNA NYC WELFARE FUND
SUMMARY OF BENEFITS**

BENEFIT	DESCRIPTION	ADMINISTRATOR/CARRIER	ELIGIBILITY
SUPPLEMENTAL MAJOR MEDICAL	<p>\$100 Annual deductible, pays 80% of difference between the base allowance and the charge. \$1,000 annual maximum for out-patient psychiatry. See additional coverage limitations and eligibility outlined in this book.</p>	<p>Administrative Services Only Inc. 1-888-692-7671</p>	<p>Full-Time Nurses and Dependents Part-Time Nurses Only</p>
DENTAL	<p>Deductible = \$50 individual, \$150 family, pays 100%, 80%, 50%, FT Nurses and dependents; \$1,500 annual maximum. PT Nurses only: \$600 annual maximum. Orthodontic 50% of reasonable and customary up to a \$1,500 lifetime maximum. Only dependent children (to age 19) are covered for Orthodontics. Aetna Network</p>	<p>Aetna 1-877-238-6200 www.aetna.com</p>	<p>Full-Time Nurses and Dependents Part-Time Nurses Only</p>
PRESCRIPTION COVERAGE	<p>No co-pays for generic medications (retail or mail) Co-pay for preferred drugs brands Retail: 15% (\$20 min/\$40 max) Mail: 15% (\$40 min/\$80 max) Co-pay for non-preferred brands Retail: 30% (\$35 min/\$55 max) Mail: 30% (\$70 min/\$140 max) Mandatory mail order for maintenance medications after 2 fills at retail. Some prescriptions are subject to prior authorization and step therapy. Mandatory generics - if brand used members cost will be subject to additional ancillary fees. No annual maximums.</p>	<p>OptumRx 1-888-691-0130 www.optumrx.com</p>	<p>Full-Time Nurses and Dependents Part-Time Nurses Only</p>

OPHTHALMOLOGY	\$20 reimbursement one every two years toward an exam. Must submit with copy of EOB from base carrier.	Administrative Services Only Inc. 1-888-692-7671	Full-Time and Part-Time Nurses and their Dependents
PODIATRY	\$30 per visit, maximum 5 visits annually. Must submit with copy of EOB from base carrier.	Administrative Services Only Inc. 1-888-692-7671	Full-Time and Part-Time Nurses and their Dependents
OPTICAL PLAN	\$100 every 24 months. Network providers available.	Administrative Services Only Inc. 1-888-692-7671	Full-Time Nurses and Dependents Part-Time Nurses Only
HEARING AIDS	\$200 every 3 years. Batteries, repairs and hearing aids.	Administrative Services Only Inc. 1-888-692-7671	Full-Time and Part-Time Nurses and their Dependents
LONG TERM DISABILITY	26 weeks waiting period; maximum \$400 month (offset by social security and/or retirement benefits), for illness a maximum of 24 months, not to exceed age 65 for accidental injury, payment to age 65 if continuously and totally disabled.	Administrative Services Only Inc. 1-888-692-7671	Full-Time Nurses Only
LIFE INSURANCE	\$25,000 Full -Time Nurses \$20,000 Part-Time Nurses \$10,000 Spouse of FT Nurses \$2,500 child of FT Nurses	Administrative Services Only Inc. 1-888-692-7671 (underwritten by Hartford)	Full-Time and Part-Time Nurses Only
WELL BABY CARE	\$600 life time each account	Administrative Services Only Inc. 1-888-692-7671 (underwritten by Hartford)	Full-Time and Part-Time Nurses Only
ORTHOTICS	100% up to \$400 annual maximum; lifetime maximum \$2,400.	Administrative Services Only Inc. 1-888-692-7671 (underwritten by Hartford)	Full-Time and Part-Time Nurses Only

ELIGIBILITY

You and your dependents are eligible for the benefit coverages shown in this booklet as long as you are actively employed within the bargaining unit covered by the collective bargaining agreement between the New York State Nurses Association and the City of New York and the New York City Health and Hospitals Corporation. You become eligible on the date of your employment in a covered position. If you are not at work on the day you would normally become eligible, you become eligible on the day you return to work.

DEPENDENT ELIGIBILITY

Eligible dependents are your spouse (except in the event of divorce or annulment), your domestic partner (if registered as such with the NYC clerk and has satisfied the criteria below), unmarried children from live birth to age 19 for all benefits and from live birth to age 26 for life insurance.

Unmarried children up to twenty-three years of age are eligible provided they depend wholly upon you for support and maintenance and are full-time students in an educational institution. Student verification must be submitted every year for the school year September - May. All dependent children up to twenty-six years of age are covered for prescriptions and supplemental major medical provided an adult certification form is completed. Stepchildren, foster children and legally adopted children or children placed for adoption may be included, as are natural children, provided they depend upon you for support and maintenance.

Except for a child at birth, if a dependent is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependents will not be covered until given a final release by the doctor for any such confinement.

If your child is mentally ill, developmentally disabled or mentally retarded, or has a physical handicap when insurance would end because of the child's age, insurance (other than life) would be continued if, within thirty-one days after the date benefits would normally cease, you submit proof of your child's incapacity to Administrative Services Only, Inc.

No one will be eligible as a dependent while covered as an employee or while in active military service. No dependent may be insured by more than one employee who is a member of this Plan.

The domestic partner and the employee must complete a notarized statement that they satisfy at least two items from the list of criteria in the declaration of

financial interdependence. Where the employee and the domestic partner choose not to submit such notarized statement, they have the option of filing a joint declaration of financial interdependence.

Generally, the trustees establish January 1 through December 31 as the Plan "contract year." Occasionally, benefits are introduced or modified on a date other than January 1. You will be notified of change in benefits at the time it occurs.

ENROLLMENT

Enrollment forms are provided to each new employee by officers of the NYSNA Local Bargaining Unit during the orientation. If you do not receive the cards (Aetna, OptumRx & NYSNA Membership) within two weeks of employment, please request it immediately from the council chairperson or from Administrative Services Only, Inc.

Prompt enrollment in the Plan is essential and is the responsibility of each plan participant.

As a City employee you must also enroll in the Basic Employee Health Benefits Program. Be certain you complete the forms for that plan and have a copy of the benefits provided under that plan. Questions about the City's basic plan should be directed to the human resources department at the agency at which you are employed or to the association nursing representative who services the NYSNA Local Bargaining Unit at your agency.

Termination of Benefits

ALL BENEFITS COVERAGE ENDS IMMEDIATELY IF THE PLAN IS TERMINATED OR IF YOUR EMPLOYER CEASES TO BE A CONTRIBUTING EMPLOYER OR TO MAKE FULL, TIMELY AND ADEQUATE CONTRIBUTIONS TO THE PLAN, or

- A. Termination of Employment
- B. A decrease in benefits due to a change in the status from a full-time employee to a part-time employee or to an employee on leave of absence no longer on active payroll status for whom the City of New York no longer makes contributions to the Plan.
- C. Loss of coverage due to divorce or legal separation.
- D. Loss of eligibility for coverage as a dependent.

Pre-Existing Condition

The Plan has no exclusions or restrictions based on pre-existing conditions with respect to covered individuals.

Rescissions

The Plan shall not take back any plan of coverage with respect to an enrollee once the enrollee is covered under the Plan or coverage involved, except that this shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan or coverage.

Women's Health and Cancer Treatments

Women's health and cancer treatments are covered on the same basis as any other claim.

Newborns' and Mothers' Health Protection

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HOW TO FILE A CLAIM

If the claim form is unavailable at your institution, call or visit the benefit administrator carrier's directly:

Aetna (Dental Benefit)
1-877-238-6200 or
www.aetna.com
PO Box 14094
Lexington, Kentucky 40512

Administrative Services Only, Inc.
1-888-692-7671
www.asonet.com
PO Box 9005
Lynbrook, NY 11563

Read the instructions on the claim form carefully and include any required attachments when you return the completed claim form. All correspondence

and claim forms should be forwarded to Administrative Services Only, Inc. or Aetna, for dental benefits.

If you do not receive a settlement within ninety days after you return the completed form, or 180 days if you were notified of a delay, you should contact Aetna for dental and Administrative Services Only, Inc. for all other benefits.

Claims for benefits provided under the City's basic plan should be filed according to the City's instructions. Correct routing will expedite payment of claims. If you have questions about filing, contact your human resources department or Administrative Services Only, Inc.

Supplemental Major Medical: Your major medical coverage is supplemental to your base plan. After you have received payment under your base plan or notice of denial of payment, submit a copy of the Explanation of Benefits along with a bill from your physician or hospital or a completed superimposed major medical benefit claim form to Administrative Services Only, Inc. Please be sure the bill includes CPT and ICD9 codes.

Note that your coverage includes a \$100 per calendar year deductible. Payment of supplemental major medical charges which exceed \$100 will be made at the rate of eighty percent of difference between the base allowance and the usual, customary and reasonable charges.

Appliances, anesthesia, emergency room treatment, private duty nursing: Submit claims to the base plan first. Upon receipt of payment or denial of payment by the base plan, submit a copy of the explanation of benefits and the bill for services from the provider or a completed superimposed major medical benefit claim form to Administrative Services Only, Inc. These benefits are subject to certain deductible amounts and maximum reimbursement amounts. Refer to detailed explanation of each benefit.

Dental: Obtain a claim form from Aetna. Submit completed form to Aetna for payment.

Basic Drug Plan: Your pharmacy card can be used at any participating pharmacy. If necessary, OptumRx reimbursement forms can be obtained from OptumRx. (See "Basic Prescription Drug Benefits" for detailed explanation.)

Maintenance Drug Plan: Obtain a profile form from OptumRx or complete a profile online by going to OptumRx.com. Send profile form with original prescription to OptumRx for drug supply. When your original prescription is returned, you will be provided with instructions from OptumRx how to fill future maintenance prescriptions or refills.

Hearing Aid, Ophthalmology and Podiatry: Obtain a claim form from Administrative Services Only, Inc. Submit completed form to Administrative Services Only, Inc. for payment.

Optical Benefit: Obtain a form and a list of participating providers from Administrative Services Only, Inc. Visit a participating provider or submit a claim directly.

Well Baby Care: After you have received payment under your base plan, or notice of denial of payment, submit a copy of the explanation of benefits along with a bill from your physician or hospital or a completed claim form to Administrative Services Only, Inc.

Long-Term Disability: Submit claim to Administrative Services Only, Inc. Administrative Services Only, Inc. will request statements from your attending physician. Administrative Services Only, Inc. initiates and continues payments through the length of disability or to Plan's stated maximum.

Life Insurance: Notify Administrative Services Only, Inc. of death of member or eligible dependent. A claim form will be sent to the beneficiary to be completed. An original death certificate is required.

HOW TO APPEAL A CLAIM

Claim Review and Appeals

1. Dental

When filing a Dental claim appeal to Aetna, you or your authorized representative must contact Aetna verbally or in writing with the reason of your appeal within 180 days for a level one appeal and 60 days for a level two appeal, of the adverse benefit determination. Send your request for an appeal with all pertinent information to:

Dental Appeals Resolution Team
PO Box 14080
Lexington, KY 40512
877-238-6200

2. Prescription

When filing an appeal for prescription medication to OptumRx, you or your authorized representative must contact OptumRx verbally or in writing with the reason of your appeal within 180 days. Send your request for an appeal with all pertinent information to:

OptumRx Appeals
CA 106-0286
3515 Harbor Blvd.

3 Appeal Process

After completion of the Dental or Prescription appeals process described above, or in the case of any other benefit claim, the following Claims Review and Appeals Procedure applies.

4. Authority of the Fund

The Fund is an employee benefit trust fund, financed by contributions fixed by collective bargaining or other written agreements, and administered by a Board of Trustees pursuant to an Agreement and Declaration of Trust, which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted a Plan of benefits set forth and described by this Plan Document and Summary Plan Description (SPD). Under the Trust Agreement and SPD, the Trustees may, in their discretion, revise, discontinue, improve, reduce, modify or make changes in the Plan, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application or enforcement of the terms of the Plan and SPD, and all determinations on benefit claims and appeals, are subject to the discretion of the Board of Trustees, whose determinations are final and binding.

5. Request for Review of Disputed Claims

If you have presented a claim for benefits under this SPD, you may file a request for review of its disposition or adverse benefit determination by appealing to the Board of Trustees of the Fund in writing, within 180 days after receiving written notice of the Fund's action. Send your appeal to the Fund office.

6. Additional Information

If additional information is needed, it will be requested by the Fund, and absent the timely provision of the information, may require the denial of the claim or appeal.

7. Finality

In deciding claims, the Board of Trustees has broad discretion to interpret and apply the terms of this plan and SPD.

The determination of the Fund will be final and binding if an objection or request for review is not timely filed. The decision of the Board of Trustees of the Fund will be final and binding on any appeal timely presented to it.

The Claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act following an adverse benefit determination on review, to the extent applicable or under another applicable law. If your claim involves disability benefits, you and your plan may have other voluntary alternative dispute options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

No lawsuit shall be brought to recover benefits under this Fund unless the Claimant has exhausted the Claims Review and Appeals Procedure provided by the Fund, and the lawsuit is filed within one (1) year from the date of the final decision.

8. Notification and Right to Comment and to Information

Upon any adverse benefit determination, the Fund will notify the Claimant of this Claims Review and Appeal Procedure and its time limits. A Claimant may review pertinent documents and submit written issues and comments, records or other information relating to the claim. A Claimant shall be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. All comments, documents, records, and other information submitted by the Claimant will be taken into account at any stage of the Claims Review and Appeals Procedure and process. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, such will be stated and a copy will be provided upon request. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request. The Fund will provide for the identification of medical or vocational experts whose advice was relied on in connection with an adverse benefit determination.

9. Urgent Care, Pre-Service and Post-Service Claims

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a

prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Aetna Dental Benefit determination	36 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit in whole or in part, on approval in advance of obtaining medical care. There are, for example, Claims subject to pre-certification or pre-authorization. Please see the cost management section of your summary plan description for further information about Pre-Service Claims if pre-approval of services are applicable under your plan of benefits.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days

Ongoing courses of treatment:

Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:

Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination	60 days

In case of the failure of you or your representative to follow the Plan’s procedures for filing pre-service claims, which are described separately in the SPD, you or your representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits, as soon as possible but not later than 5 days (24 hours in the case of a failure to file with respect to a claim involving urgent care) following the failure.

In the case of urgent or concurrent care claims, notification and right to review and appeal shall be in accordance with regulations of the United States Department of Labor, with initial appeal within the procedures and time limits set forth by the Fund’s utilization reviewer, which are described separately in the SPD. In the case of an adverse benefit determination concerning an urgent or concurrent care claim, the expedited review process applicable to such claims will be included with the determination. After completing such appeal to the utilization review, the Claimant shall also have a right of appeal within the Fund as described in this Claims Review and Appeal Procedure.

10. Medical Judgments

In deciding any appeal based in whole or in part on a medical judgment, the Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the adverse benefit determination nor the subordinate of any such individual.

11. Overpayments

The Plan may recover or recoup the amount of any erroneous payment, with interest, against pending or future benefits in accordance with law and regulations, and also take such legal action as may be necessary for recovery.

RETIREMENT

If you are eligible to receive a pension from the City of New York you and your eligible dependents may be entitled to certain health benefits which are provided by the New York City Retiree Health and Welfare Plan. This plan is constituted of several organizations, one of which is the New York State Nurses Association. It is a separate plan, administered by a separate board of trustees. For further information about benefits covered by this Plan, contact:

Administrative Services Only, Inc.
1-888-692-7671
www.asonet.com

POLICIES & PROCEDURES

The board of trustees of the New York State Nurses Association Welfare Plan for New York City Employed Registered Professional Nurses is responsible for the management and oversight of plan operations. These policies and procedures are adopted to assist in carrying out these obligations.

1. Policies

To ensure optimum utilization of plan benefits, trustees shall maintain systematic communication with plan participants. Basic information regarding the nature and scope of plan benefits, eligibility, criteria, claims processing and the role and responsibilities of trustees shall be available to plan participants on an ongoing basis. Plan participants are encouraged to communicate to trustees their assessment of the adequacy of benefits and the effectiveness of plan operations.

2. Procedures

- a. Upon notification of City employment of eligible participants, the Plan shall provide the individual registered professional nurse with plan enrollment, benefit and claims processing information.
- b. The summary plan description will be provided to each eligible plan participant upon employment. A summary annual report will also be mailed to plan participants.
- c. Modification of benefits or plan operations implemented in the interval between publication of revisions to the summary plan description are reported to plan participants via written announcements. Such modifications constitute revisions to the summary plan description and shall be binding upon plan participants.

- d. Plan representatives shall hold periodic meetings with plan participants at employment sites for purposes of clarification of comments and suggestions.
- e. Plan representatives shall report regularly at trustee meetings regarding plan participants' communication with them.
- f. Trustees and plan representatives shall meet annually with the Executive Council of Nursing Practitioners of the City of New York and the New York City Health and Hospitals Corporation for purposes of clarification of benefits and operations and solicitation of comments and suggestions.
- g. Plan participants may communicate their suggestions regarding benefits and operations in writing to the board of trustees. Written recommendations regarding plan benefits and operations shall be reviewed by the board at regularly scheduled meetings.
- h. At its discretion, the board of trustees may invite plan participants or representatives of the Executive Council to trustee meetings for discussion of plan benefits and operations.
- i. The board of trustees may from time to time utilize such other communication mechanisms as it deems necessary or desirable.

SUPPLEMENTAL MAJOR MEDICAL

This coverage is supplemental to the basic New York City Health Program and is subject to the following:

Who is Covered

Full-time nurses and your eligible dependents. Part-time nurses only are covered. Dependents of part-time nurses are covered for appliances, anesthesia and emergency room care (see coverage.)

Deductible - The deductible for any calendar year will be the sum of a cash deductible of \$100 per person and the amount of benefits provided under the employer's group medical plan and the extended coverage benefit payment.

Co-insurance - The plan pays 80 percent of the usual and customary charges after participant satisfies the deductible.

Psychiatric treatment while not confined to a hospital -
 covered charge limit \$50 per visit
 co-insurance 50% after satisfying the deductible

Note: Psychological testing is not covered.

Professional fees will include those of a:

- a. Physician.
- b. Psychologist licensed under the laws of New York State.
- c. Social worker who is certified and registered. The person's name must be on the list of social workers who are qualified for payment under Chapter 893 of New York State laws. The list is maintained by the New York Board of Social Work.

Also covered are duly licensed registered professional nurses performing medically necessary covered services that are within the lawful scope of their license. However, coverage for such services will not be provided if the service is performed in a physician's office, a general hospital, a nursing home, or a facility providing health related services as defined in either section 2801 of New York's public health law or subdivision six of section 1.03 of New York's mental hygiene law.

When calculating the period in which "deductibles" apply - e.g., if the deductible you must pay is \$50.00 and you incur that expense in January 2014 you have satisfied the deductible for calendar year 2014. In the event you do not incur deductibles during the first nine months of the calendar year, deductibles incurred in the remaining three months may be credited in the following plan year.

Charges Covered - Covered charges are as follows:

1. Charges covered under your base medical plan made by a doctor for diagnosis, treatment and surgery.
2. Doctor's charges for dental work or treatment will be covered if:
 - a. The work or treatment is needed because of accidental injury to sound natural teeth or to the jaw which occurs while insured.
 - b. The work or treatment is needed because of oral dental surgery done while the person is confined in a hospital for at least eighteen hours: such confinement must be required because of a hazardous medical condition of the person. Oral dental surgery is limited to charges for cutting procedures for diseases or the extraction of impacted teeth.
3. Charges for private duty nursing services made by a registered nurse (RN) or a licensed practical nurse (LPN) recommended and approved by a legally qualified physician.

4. Charges for prosthetic appliances to replace a limb or organ, if the appliance is the first one or a replacement due to pathological changes or normal growth, casts, splints, trusses, braces, crutches.
5. Charges for the use of radium and radioactive isotopes, rental of wheel chairs, hospital-type beds and equipment to give oxygen, rental of an iron lung or other mechanical equipment required to treat respiratory paralysis.
6. Charges for local ambulance service, medication, x-ray services, laboratory tests, oxygen, physiotherapy.
7. Charges incurred for the administration of anesthesia.

Doctor means:

- a. A physician legally licensed to practice medicine and surgery.
- b. Any other legally licensed practitioner of the healing arts who renders services within the scope of his or her license. For health insurance expenses, such services will include those covered under the group policy for which benefits must be provided by law when rendered by that practitioner.

This term does not include a resident doctor, an intern or a person in training.

Charges/fees/expense will not include any amount:

More than the reasonable and customary Charge in the local where incurred.

- a. For a service or supply not generally accepted in medical practice as needed in the diagnosis or treatment of the patient's condition.
- b. For repeated tests which are not needed.
- c. Which exceeds your basic medical frequencies and limitations.
- d. When requirements of coverage is not satisfied under basic plan. This could include but is not limited to, out of network services and precertifications.
- e. These amounts will be determined by NYSNA. NYSNA may make use of the certification by a professional or peer review group of the extent to which a service or supply is needed for the diagnosis or treatment of the patient's condition.

Hospital means:

A legally constituted and operated institution which has on the premises organized facilities (which include those of diagnosis and major surgery) to care for and treat sick and injured persons. There must be supervision by a staff of doctors with a registered nurse (RN) on duty at all times.

This term does not include an institution or part of one used mainly for rest care, nursing care, convalescent care, care of the aged, care of the chronically ill, custodial care, care of drug addicts or alcoholics. or rehabilitative care.

Not Covered

Covered charges do not include charges for services and supplies:

1. Not ordered by a doctor.
2. For dental work. treatment or dental x-rays (except as shown in item 2 of "Covered Charges" or because of an accidental injury to sound natural teeth or to the jaw which occurs while insured).
3. For transportation (except as shown in item 6 of "Covered Charges").
4. In a Veterans' Administration Hospital.
5. For hearing aids or their fitting.
6. Needed because of war, declared or not.
7. Which an insured person would not legally have to pay if there were no insurance.
8. For health exams (except if needed because of an accidental injury or sickness).
9. For an injury or sickness due to employment with an employer or self employment.
10. For drugs and medicines.

LIMITATIONS

Benefits will not be paid for, and the term "covered charges" will not include charges for:

1. diagnosis and treatment of:
 - a. weak, strained, unstable flat feet;
 - b. any tarsalgia, metatarsalgia or bunion; except for operations which involve the exposure of bones, tendons or ligaments

or

2. treatment of:
 - a. toe nails, other than removal of nail matrix or root
 - b. superficial lesions of the feet, such as corns, callouses, and hyperkeratosis
3. eye refractions
4. eyeglasses or contact lenses or their fitting
5. analysis of vision or the testing of its acuity
6. biomicroscopy, field charting or aniselkonic investigation
7. orthoptic or visual training
8. service of devices to correct vision or for advice on such services

9. the following on account of mental, nervous or emotional condition
 - a. educational testing or training
 - b. room and board and other services made by hospitals for confinement
10. *custodial care.
*custodial care means:
 - a. room and board and other institutional or nursing services which are provided for a person due to his or her age or mental of physical condition mainly to aid the person in daily living;
or
 - b. medical services which are given merely as care to maintain the person's present state of health and which cannot be expected to improve a medical condition to a great extent.
11. the following rendered to a newborn child in the course of the first fourteen days after such child's birth:
 - a. services
 - b. supplies
 - c. treatment

This will not apply to the extent such charges are in excess of those which would have been incurred for:

1. regular and customary well baby care. This includes charges for room and board and circumcision; or
2. the following routine care not related to, or needed for, treatment of injury or sickness:
 - a. immunizations
 - b. nursing care
 - c. medical exams or test of any kind

APPLIANCES

Who Is Covered

Full- and part-time nurses and their eligible dependents.

Covered Benefits

Charges for durable medical equipment and appliances such as crutches, wheelchairs, artificial limbs and orthopedic appliances. These charges shall only include the reasonable and customary charges for such appliances.

Payment is as follows;

Deductible.....\$ 15.00 per person

ANESTHESIA

Who is Covered

Full- and part-time nurses and their eligible dependents.

Covered Benefits

Charges incurred for the administration of anesthesia to a covered person by a legally qualified physician, other than the surgeon performing or assisting in the operation. The charges incurred must be in connection with a surgical operation. These charges shall only include the reasonable and customary charges for such service.

Reimbursement:

The physician's charges up to a maximum of \$50 in case of an operation for which the anesthesia time is less than two hours and a maximum of \$100 in the case of which the anesthesia time is two hours or more. Anesthesia time starts with the beginning of the administration of anesthesia and ends when the anesthesiologist is no longer in personal attendance.

Not Covered

Charges incurred on account of injury or sickness connected with employment by any employer.

EMERGENCY CARE

Who is Covered

Full- and part-time nurses and their eligible dependents.

Covered Benefits

Benefits are payable if a person, while covered, undergoes emergency medical care and treatment administered by a legally qualified physician in the physician's office, or in the out-patient department of a legally constituted and operated hospital while such person is not confined as an admitted in-patient.

Charges Included:

1. Charges made by a legally constituted and operated hospital for services, supplies and treatment.
2. Charges made by a legally qualified physician, other than an employee of a hospital, for such care and treatment.

Benefits will be paid if charges are incurred within 24 hours of the injury, or within a period of 24 hours commencing with the time the first charge was incurred in connection with the care and treatment of a sickness, provided that the administering physician shall certify that such care and treatment was performed as the result of an emergency. Subscriber will be reimbursed \$400 in a calendar year for emergency care benefit.

In case of sickness, all charges incurred due to the same or related causes and not separated by your return to work, or by 3 months in the case of your dependents, shall be considered as incurred with respect to the same sickness.

In addition, all dental procedures requiring surgery while confined to a legally constituted and operated hospital for at least 18 hours as an inpatient will be reimbursed for expenses incurred up to \$200 in a calendar year. Such treatment and hospital confinement must be recommended and approved by a physician legally licensed to practice medicine and surgery.

Not Covered

Charges for services and treatment not recommended and approved by a legally qualified physician due to an injury connected with employment with any employer, due to pregnancy, for dental work or treatment, dental x-ray or eye refraction, for any preoperative or post-operative care, an opening cutting operation or confinement in a hospital, or for nurses' fees.

COORDINATION OF BENEFITS

Coordination of benefits is a method of determining the amount payable by each plan when a claimant is covered by more than one plan, such as a husband or wife covered under both his or her own plan and the spouse's plan.

The insurance industry has developed guidelines for determining which plan most directly covered the individual for whom charges are incurred.

Coordination of benefits helps to prevent out-of-pocket expenditures by claimants and duplicate insurance payments.

Claim forms are designed to facilitate the coordination of benefits process. The claim form must be completed in full. A claim form cannot be accepted if the employee section is not completed in full - including all spouse information.

Plan means any plan that provides medical or dental care coverage:

- a) by group insurance, or by any other method of coverage for persons in a group;
- b) by any governmental plan;
- c) required by law;
- d) by a "no-fault motor vehicle plan."

Medicare means Title XVII of the Federal Social Security Act, as it now reads or as it may be changed in the future. A person who is eligible for coverage under Medicare will be deemed to have all the coverages for which he or she is eligible under Medicare.

No-fault motor vehicle plan means a compulsory motor vehicle plan that provides payments for medical or dental care which are payable, in whole or in part, without regard to fault.

The order of payment is determined as follows:

1. If one plan does not have a coordination of benefits provision, it shall be primary.
2. If the patient belongs to the group covered under one plan and is covered only as a dependent under another, the Plan covering the group to which the patient belongs shall be primary.
3. If the patient is a dependent child covered under the Plans of both parents, the Plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have a birthday on the same month and day, the Plan which has covered a parent longer shall be primary. However, if one plan does not use this rule but instead uses a rule based on the gender of the parent, and if as a consequence the Plans do not agree on which plan is primary, then the father's plan shall be primary.

If the parents are divorced or separated:

1. If a court decree has established which parent has financial responsibility for the child's health care expenses, then that parent's plan shall be primary.
2. If financial responsibility has not been established, then the Plan of the parent with custody shall be primary.
3. If the parent with custody has remarried and the child is covered as a dependent under the Plan of the stepparent, the order of primacy is as follows:
 - a. the Plan of the parent with custody
 - b. the Plan of the stepparent
 - c. the Plan of the parent without custody
4. If the patient is covered as an active employee and is also covered as a retired or laid-off employee under another plan, the Plan covering the patient as an active employee shall be primary. However, if one plan does not use this rule and if as a consequence the Plans does not agree on which plan is primary, this rule shall be ignored.
5. If none of the above applies, then the Plan under which the patient has been enrolled the longest shall be primary.

- c. Under applicable insurance law is considered a "physician" for purposes of this coverage;
- d. Has the medical training and clinical expertise suitable to treat your condition;
- e. Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- f. A physician is not you or related to you.

3. Course of Dental Treatment:

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more dentists to treat a dental condition that was diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts on the date your dentist first renders a service to correct or treat the diagnosed dental condition.

4. Usual and Customary means the actual fee charged by a dentist for a service rendered, but only to the extent that the fee is reasonable, taking into consideration the following:
- a. the usual fee which the individual dentist most frequently charges the majority of his or her patients for a service rendered.
 - b. the prevailing range of fees charged in the same area by dentists of similar training and experience for the service rendered.
 - c. The Usual and Customary charge is derived from Fair Health and is updated regularly.

COVERAGE FOR DENTAL WORK COMPLETED AFTER TERMINATION OF COVERAGE

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

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

"Ordered" means:

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

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.

WHEN TO GET AN ADVANCE CLAIM REVIEW

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than \$350. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna. Aetna may require supporting x-rays and other diagnostic records. 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 benefits payable by the Plan. You and your dentist can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits 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

GETTING AN ADVANCE CLAIM REVIEW

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for the proposed services. Knowing ahead of time

which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

IMPORTANT NOTE - The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

ALTERNATE TREATMENT RULE (GR.9N-20-015-01)

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Plan's coverage will be limited to the cost of the least expensive service or supply that is:

Customarily used nationwide for treatment, and deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

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

THE AETNA DENTAL PROGRAM NETWORK PROVIDERS

Under the Aetna Dental program your Network Provider has agreed to accept fees paid by the Plan. You can find a Aetna Provider by visiting www.aetna.com or call 1-877-238-6200. When visiting your dentist identify yourself as an Aetna member.

The Choice is Yours

You have a choice each time you need dental care:

Using Network Providers

Your out-of-pocket expenses will be lower when your care is provided by a network provider.

The plan begins to pay benefits after you satisfy a deductible.

You share the cost of covered services and supplies by paying a portion of certain expenses (your payment percentage). Network providers have agreed to provide covered services and supplies at a negotiated charge. 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%.

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 be responsible for deductibles, payment percentage and copayments, if any.

You will receive notification of what the Plan has paid toward your covered expenses. It will indicate any amounts you owe towards your deductible, copayment, payment percentage or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Aetna's Member Services if you have questions regarding your statement.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice.

Using Out-of-Network Providers

You can obtain dental care from dental providers who are not in the network. The plan covers out-of-network services and supplies, but your expenses will generally be higher. You must satisfy a deductible before the Plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your payment percentage).

If you're out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.

You must file a claim to receive reimbursement from the Plan.

Refer to the *Schedule of Benefits* for details about any deductibles, copays, payment percentage and maximums that apply. There is a separate maximum that applies to orthodontic treatment.

BENEFIT PERIOD

The benefit period begins on each January 1 and ends on the date insurance terminates or on December 31 of the calendar year in which it begins, whichever is earlier.

DENTAL

Plan Year Maximum

Full Time Nurses and eligible dependents \$1,500

Part Time Nurses \$ 600

Ortho lifetime Maximum \$1,500

Only dependent children of full time nurses (up to age of 19)

are covered for orthodontic services. Appliances must be placed prior to age 19. All orthodontic work must be completed by age 19 or age 23 if full time student, even if the bands are placed before the dependents 19th or 23rd birthday.

Deductible \$ 50 single
\$150 family

(Excluding diagnostic and preventative care)

Dental Care Schedule

The dental care schedule is 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.

PPO Dental Expense Coverage Plan

The following additional dental expenses will be considered covered expenses for you and your covered dependent if you have medical coverage and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/ Cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

Additional Covered Dental Expenses

One additional prophylaxis (cleaning) per year.
Scaling and root planing, (4 or more teeth); per quadrant;
Scaling and root planing (limited to 1-3 teeth); per quadrant;
Full mouth debridement;
Periodontal maintenance (one additional treatment per year); and
Localized delivery of antimicrobial agents. (Not covered for pregnancy)

Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the Plan.

The payment percentage applied to the other covered dental expenses above will be 100% for network expenses and 100% for out-of-network expenses. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum. Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses.

The deductible payment percentage and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

You may receive services and supplies from network and out-of-network providers. Services and supplies given by a network provider are covered at the network level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an out-of-network provider are covered at the out-of-network level of benefits shown in the *Schedule of Benefits*.

Type A Expenses:

Diagnostic and Preventive Care: Reimbursement at 100% of the U & C

Visits and X-Rays

1. Office visit during regular office hours, for oral examination
2. Routine comprehensive or recall examination (limited to 2 visits every year)

3. Problem-focused examination (limited to 2 visits every year)
4. Prophylaxis (cleaning) (limited to 2 treatments per year)
 - a. Adult
 - b. Child
5. Topical application of fluoride, (limited to one course of treatment per year and to children under age 19)
6. Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 14)
7. Bitewing X-rays (limited to 1 set per year)
8. Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
9. Vertical bitewing X-rays (limited to 1 set every 3 years)
10. Space Maintainers - Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
 - a. Fixed (unilateral or bilateral)
 - b. Removable (unilateral or bilateral)

Type B Expenses:

Basic Restorative Care: Reimbursement at 80% of the U & C

Visits and X-Rays

1. Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
2. Emergency palliative treatment, per visit

X-Ray and Pathology

1. Periapical x-rays (single films up to 13)
2. Intra-oral, occlusal view, maxillary or mandibular
3. Upper or lower jaw, extra-oral
4. Biopsy and histopathologic examination of oral tissue

Oral Surgery

1. Extractions
2. Erupted tooth or exposed root
3. Coronal remnants
4. Surgical removal of erupted tooth/root tip
5. Impacted Teeth
6. Removal of tooth (soft tissue)
7. Removal of tooth (partially bony)
8. Removal of tooth (completely bony)

9. Odontogenic Cysts and Neoplasms
 - a. Incision and drainage of abscess
 - b. Removal of odontogenic cyst or tumor
 - c. Other Surgical Procedures
 - d. Alveoplasty, in conjunction with extractions - per quadrant
 - e. Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
 - f. Alveoplasty, not in conjunction with extraction - per quadrant
 - g. Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
 - h. Sialolithotomy: removal of salivary calculus
 - i. Closure of salivary fistula
 - j. Excision of hyperplastic tissue
 - k. Removal of exostosis
 - l. Transplantation of tooth or tooth bud
 - m. Closure of oral fistula of maxillary sinus
 - n. Sequestrectomy
 - o. Crown exposure to aid eruption
 - p. Removal of foreign body from soft tissue
 - q. Frenectomy
 - r. Suture of soft tissue injury

Periodontics

1. Occlusal adjustment (other than with an appliance or by restoration)
2. Root planing and scaling, per quadrant (limited to 4 separate quadrants every 12 rolling months)
3. Root planing and scaling - 1 to 3 teeth per quadrant (limited to once per quadrant every 12 rolling months)
4. Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
5. Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
6. Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
7. Gingival flap procedure - 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
8. Periodontal maintenance combined with prophylaxis frequency, no prior periodontal history required
9. Localized delivery of antimicrobial agents
10. Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 12 months
11. Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 12 months
12. Soft tissue graft procedures
13. Clinical crown lengthening, hard tissue

Endodontics

1. Pulp capping
2. Pulpotomy
3. Apexification/ recalcification
4. Apicoectomy
5. Root canal therapy including necessary X-rays
 - a. Anterior
 - b. Bicuspid
 - c. Molar

Restorative Dentistry - Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.

(Multiple restorations in 1 surface will be considered as a single restoration.)

1. Amalgam restorations
2. Resin-based composite restorations (other than for molars)
3. Pins
 - a. Pin retention-per tooth, in addition to amalgam or resin restoration
4. Crowns (when tooth cannot be restored with a filling material)
 - a. Prefabricated stainless steel
 - b. Prefabricated resin crown (excluding temporary crowns)
5. Recementation
 - a. Inlay
 - b. Crown
 - c. Bridge
6. Core buildup, including any pins

General Anesthesia and Intravenous Sedation (only when medically necessary and only when provided in conjunction with a covered surgical procedure)

Type C Expenses: Major Restorative Care: Reimbursement at 50% of U & C

Restorative. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 7 years-see *Replacement Rule*). Prosthetic replacement 7 year rule applies to replacements of any previously installed crowns. Prosthetic replacement 5 year rule applies to replacements of any previously installed inlays, onlays, bridgework and dentures.

1. Inlays/Onlays Labial Veneers
 - a. Laminate - chairside
 - b. Resin laminate - laboratory
 - c. Porcelain laminate - laboratory

2. Crowns

- a. Resin
- b. Resin with noble metal
- c. Resin with base metal
- d. Porcelain/ceramic substrate
- e. Porcelain with noble metal
- f. Porcelain with base metal
- g. Base metal (full cast)
- h. Noble metal (full cast)
- i. 3/4 cast metallic or porcelain/ceramic

3. Post and core

Prosthodontics-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 7 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 7 years. (See *Replacement Rule*.) Prosthetic replacement 7 year rule applies to replacements of any previously installed crowns. Prosthetic replacement 5 year rule applies to replacements of any previously installed inlays, onlays, bridgework and dentures. Bridge Abutments (See Inlays and Crowns)

1. Pontics

- a. Base metal (full cast)
- b. Noble metal (full cast)
- c. Porcelain with noble metal
- d. Porcelain with base metal
- e. Resin with noble metal
- f. Resin with base metal

2. Removable Bridge (unilateral)

- a. One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- b. Complete upper denture
- c. Complete lower denture
- d. Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
- e. Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- f. Stress breakers

- g. Interim partial denture (stayplate), anterior only
 - h. Office reline
 - i. Laboratory reline
 - j. Special tissue conditioning, per denture
 - k. Rebase, per denture
 - l. Adjustment to denture more than 6 months after installation
 - m. Dental Implants
3. Full and partial denture repairs
- a. Broken dentures, no teeth involved
 - b. Repair cast framework
 - c. Replacing missing or broken teeth, each tooth
4. Adding teeth to existing partial denture
- a. Each tooth
 - b. Each clasp
5. Repairs: crowns and bridges
- a. Occlusal guard (for bruxism only), limited to 1 every 3 years
6. Orthodontics - Reimbursement at 50% of U & C
- a. Interceptive orthodontic treatment
 - b. Limited orthodontic treatment
 - c. Comprehensive orthodontic treatment of adolescent dentition
 - d. Comprehensive orthodontic treatment of adult dentition
 - e. Post treatment stabilization
 - f. Removable appliance therapy to control harmful habits
 - g. Fixed appliance therapy to control harmful habits

Rules and Limits That Apply to 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.

Orthodontic Treatment Rule: Orthodontic coverage is only for covered dependent children. Appliances must be placed prior to age 19. All orthodontic work must be completed by age 19 or age 23 if a full-time student, even if the bands were placed before the dependent's 19th or 23rd birthday.

The Plan does not cover the following orthodontic services and supplies:

- a. Replacement of broken appliances
- b. Re-treatment of orthodontic cases
- c. Changes in treatment necessitated by an accident
- d. Maxillofacial surgery

- e. Myofunctional therapy
- f. Treatment of cleft palate
- g. Treatment of micrognathia
- h. Treatment of macroglossia
- i. Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces")
- j. Removable acrylic aligners (i.e. "invisible aligners")

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the Plan.

Replacement Rule

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

1. 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.
2. The present crown was installed at least 7 years before its replacement and cannot be made serviceable.
3. The present inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
4. You had a tooth (or teeth) extracted while you were covered by the Plan. Your present denture is an intermediate 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.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the Plan; and

1. The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

"Ordered" means:

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

What The PPO Dental Plan Does Not Cover

Not every dental care service or supply is covered by the Plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are medically necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

1. These dental exclusions are in addition to the exclusions that apply to health coverage.
2. Any instruction for diet, plaque control and oral hygiene.
3. 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 substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered cosmetic.
4. Crown, inlays and onlays, and veneers unless:
 - a. It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
 - or
 - b. The tooth is an abutment to a covered partial denture or fixed bridge.
5. Dental services and supplies that are covered in whole or in part:
 - a. Under any other part of this plan; or
 - b. Under any other plan of group benefits provided by the contractholder.
6. Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore

occlusion, or correcting attrition, abrasion, or erosion.

7. Except as covered in the *What the Plan Covers* section, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.
8. First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.
9. General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
10. Orthodontic treatment except as covered in the *What the Plan Covers* section.
11. Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium) .
12. Prescribed drugs; pre-medication; or analgesia.
13. 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.
14. Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
15. Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
16. Services and supplies provided in connection with treatment or care that is not covered under the Plan.
17. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
18. Surgical removal of impacted wisdom teeth only for orthodontic reasons.
19. 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:
 - a. Scaling of teeth
 - b. Cleaning of teeth
 - c. Topical application of fluoride

ADDITIONAL ITEMS NOT COVERED BY A HEALTH PLAN

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed **hospital, physician** or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Examinations:

- Any dental examinations:
 - required by a third party, including examinations and treatments required to obtain or maintain employment, or which a contractholder is required to provide under a labor agreement;
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
 - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity;
 - and any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service;
or
 - Care while in the custody of a governmental authority.

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician or dentist**.

Routine dental exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet

Work related: Any **illness** or **injury** related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your contractholder, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that *you* are not covered for a particular **illness** or **injury** under such law, that illness or injury will be considered "non-occupational" regardless of cause.

PRESCRIPTION DRUG BENEFITS

WHO IS COVERED

Full Time Nurses and their eligible dependents. Part Time Nurses are also covered; however, there is no dependent coverage for Part Time Nurses.

WHAT IS COVERED

Covered drug charges incurred while insured and on account of accidental bodily injury or sickness. These charges shall include only the reasonable and customary charges for the drugs and supplies furnished. Covered drug expenses consist of charges for legend drugs (as defined) when dispensed upon written prescription.

3-Tier Formulary Co-payment

You pay the retail pharmacy or the OptumRx Mail Order Pharmacy a co-payment according to the Plan's co-pay structure:

	Retail	Mail Order
Generic	\$0.00	\$0.00
Preferred Brand	15% (\$20 min/\$40 max)	15% (\$40 min/\$80 max)
Non Preferred Brand	30% (\$35 min/\$55 max)	30% (\$70 min/\$140 max)

1. Minimum co-payment means the minimum responsibility of the member's out of pocket expense. This amount is paid by the member if the co-payment is less than the minimum indicated.
2. Maximum copayment means the maximum responsibility of the member.

Mandatory Generics Program

The plan has a mandatory generics program. This means if you use a brand-name drug that is available as a generic you are responsible for the copayment, plus the difference in price between the generic and brand name drug. You pay this difference even if your doctor tells the pharmacy to dispense the brand name drug.

Step Therapy Program

The Plan's Step Therapy Program, requires you to try one or more specific drugs before the requested drug will be covered by your plan. For example, if

drug A and drug B both treat your medical condition, your Plan may require you to try drug A first. If drug A does not work well or is not right for you, then your Plan may cover drug B.

Prior Authorization

Prior authorization means that specific criteria must be met before your plan will cover certain drugs. Every prior authorization review is based on clinical guidelines, to make sure you and your family get the most appropriate drugs. Prior authorization may apply to a drug that is:

1. Approved to treat only a certain condition
2. More costly than other drugs used to treat the same condition or illness
3. Not yet proven to be safe and effective in treating your condition

Only you and your Health Care Provider can make decisions about your healthcare. Be sure to ask your Health Care Provider which generics or brand name drugs might be right for you. Whenever possible your Health Care Provider should prescribe another drug for you, and you'll get the medicine you need at the lowest possible cost.

Definitions

Legend drug shall mean any drug or medicine *which* is required to bear the legend, "CAUTION; Federal law prohibits dispensing without a prescription" or similar wording.

Prescription order shall mean the request for each separate drug or medication by a physician or dentist or other person legally authorized to prescribe and each authorized refill of such requests.

Retail Pharmacy Network

Upon your enrollment in the Plan you will be sent a prescription card to be used at an OptumRx Network Pharmacy.

The Retail Pharmacy Benefits covers up to a 30 day supply and one refill.

You can find a retail pharmacy by calling OptumRx at 1-888-691-0130 or visit their website at www.optumrx.com.

Exclusive Home Delivery Program

The NYSNA Welfare Plan Program is designed for both short-term prescriptions and maintenance medications (prescription drugs that treat chronic conditions). The benefit allows you to fill short term prescriptions at a local participating pharmacy but for maintenance medications, The Plan provides coverage through your Exclusive Home Delivery only.

Under your Exclusive Home Delivery Program, you can get up to a 1-month supply of a maintenance medication two times from a participating Pharmacy. After that, The Plan will cover the medication only if you order it from the OptumRx Mail Order Pharmacy. This will require a second prescription from your Health Care Provider. You also have the option of filling the original prescription directly through the OptumRx Mail Order Pharmacy.

You will receive:

1. Free Home Delivery of medication
2. Up to a 3-month supply of medication with each order
3. 24 hour access to a pharmacist

Call OptumRx at 1-888-691-0130 to start using mail order delivery, or complete the OptumRx Home Delivery form, include your prescription and co-payment and mail it to OptumRx. Be sure to ask your Health Care Provider for a 90 day prescription (with up to a one year of refill, if appropriate.) You can receive an OptumRx Home Delivery Form by calling 1-888-691-0130 or by visiting the website at OptumRx.com. The address to order your prescriptions through Home Delivery is

OptumRx
PO Box 2975
Mission, KS 66201-1375

Limitations and / Non-Covered

Covered drug expenses shall not include charges incurred for drug supplies without a prescription or for:

1. Drugs or supplies dispensed or furnished by a rest home, sanitarium, or other similar institution
2. Beauty aids, cosmetics and diet supplements
3. Diabetic medications including oral medications, insulin and diabetic supplies; if you or your eligible dependent are Medicare Eligible contact The Plan's Benefit Administrator, Administrative Services Only, Inc.
4. Professional charges for administration of prescribed legend drugs or insulin
5. Contraceptive implants, IUDs and OTC products.
6. Medicines furnished to a patient confined to a hospital or extended care facility
7. Supplies in excess of a thirty-day supply without the necessity of a refill
8. Drugs or supplies for which the insured person incurs no charge or is not legally obligated to pay

9. Charges covered under any government program or under any coverage provided or required by statute
10. Charges incurred on account of war, including armed aggression
11. Drugs provided by a physician, dentist or podiatrist incidental to their professional services rendered to the patient
12. Injectable and Chemotherapy Medications: If you or your eligible dependent are Medicare eligible, contact The Plan's Benefit Administrator, Administrative Services Only, Inc.
13. Anti-acne drugs are covered for eligible members and dependents (see dependent eligibility) up to age 25. A letter of medical necessity from your Health Care Provider is required after the age 25.
14. Non legend drugs (Legend drug is a drug that by law can be obtained only with a prescription) over the counter
15. Drugs provided through or received from the pharmacy of your employer that would normally have been available without cost to you
16. Drugs which when taken in accordance with the physician directions, have been dispensed in a quantity that is less than a thirty day supply (mail order)
17. Any therapeutic device (hypodermic needles, syringes, support garments, inhaler extended devices, and other non medical substances) regardless of their use
18. Drugs to treat Erectile Dysfunction are paid at a 50% co-payment. Six pills per 30 day (at retail) or 18 pills per 90 day supply (at mail order) are only allowed with prior authorization from your physician
19. Oral Antiseptics and Periodontal Products
20. Vaccines
21. Medication in unit dose packaging (unless only available as unit dose)
22. Oral contraceptives are covered at \$0 co-payment for generics and a \$5 co-payment for preferred brands at retail or mail order. Nuvaring, certain extended cycle generic oral contraceptives, cervical caps and diaphragms are covered at \$0 co-payment at retail or mail order.
23. Addyi prescribed for Hypoactive Sexual Desire Disorder is limited to one tablet per day
24. Drugs to treat Erectile Dysfunction are paid at a 50% co-payment. Six pills per 30 days (at retail) or 18 pills per 90 day supply (at mail order) are only allowed with prior authorization from your physician.

OPHTHALMOLOGY BENEFITS

Who Is Covered

Full-and part-time nurses and their eligible dependents

What is Covered

Benefits are payable for covered expenses incurred by an insured person for any eye examinations made by a legally qualified ophthalmologist. Covered expenses shall only include the regular and customary charges for the services or supplies furnished.

How Much

You will be reimbursed up to a maximum of \$20 per visit, per person, but not to exceed one visit with a 24 month period. To obtain a claim form call Administrative Services Only, Inc. or visit their website at www.asonet.com.

Not Covered

No payments shall be made for:

1. sunglasses, by prescription or otherwise, eyeglass lenses (including contact lenses) and eyeglass frames
2. expenses with respect to which benefits are provided under any Workers' Compensation, occupational disease or similar law
3. services or supplies for which the insured person is not required to pay

PODIATRY PLAN

Who Is Covered

Full-and part-time nurses and their eligible dependents are covered for podiatric care.

What is Covered

Any service or procedure performed by a licensed podiatrist of your choice.

Coverage Limits

You and your dependents are covered up to a maximum of \$30 per visit to any licensed podiatrist. Annual maximum; 5 visit per person.

Claim Procedure

1. Obtain a claim form by calling Administrative Services Only, Inc. or visit their website at www.asonet.com
2. Have the podiatrist complete podiatrist's portion showing payment.
3. Send claim the form to Administrative Services Only, Inc. You will receive a check for benefits as shown above.

Non-Duplication of Benefits

If an insured person is entitled to any podiatric benefits or services from another source (excluding an individual insurance policy) such benefit under this plan may be reduced to an amount which together with all other benefits will not exceed 100% of any necessary reasonable and customary item of expense covered under this plan or any such other plan.

ORTHOTICS APPLIANCE BENEFIT

Who Is Covered

Full-and part-time nurses.

Covered Benefits

Charges for non-surgical prescription Orthotic devices.

How Much

Benefits will be payable at 100% of the charge, with an annual maximum of \$400 and a lifetime maximum of \$2,400.00.

After you have received payment or notice of denial under your base plan, obtain a claim form by calling Administrative Services Only, Inc. or visit their website at www.asonet.com. Submit the claim form with a copy of the Explanation of Benefits and a copy of the bill, to Administrative Services Only, Inc.

HEARING AID BENEFIT

Who is Covered

Full-and part-time nurses and their eligible dependents are covered for hearing aids.

Coverage Limits and What is Covered

You and your eligible dependents are covered up to \$200.00 each during a 36 month period. This reimbursement covers the cost of the hearing aid, batteries and repairs.

Claim Procedures

1. Obtain a claim form by calling Administrative Services Only, Inc. or visiting their website at www.asonel.com
2. Send a copy of a doctor's note certifying a medical necessity.
3. Send a copy of a paid bill.
4. You will be reimbursed for an amount not to exceed \$200.00.

LIFE INSURANCE

Full Time Nurses Term Life Insurance	\$25,000
Part Time Nurses Term Life Insurance	\$20,000

The amount of Life Insurance for employees age 70 and over will be 50% of above amount.

FOR DEPENDENTS (Full Time Nurses Only)

Term Life Insurance Covered Spouse	\$10,000.00
Covered Children	\$ 2,500.00

Dependent children are covered from live birth to age 26.

If the life insurance coverage terminates for either yourself or your covered dependent spouse for any of the reasons outlined on page 8, you may elect to convert your life insurance policy to an individual policy. Contact Administrative Services Only, Inc. at 1-888-692-7671 for information regarding your conversion.

LONG TERM DISABILITY BENEFITS

Who is Covered

Full-time nurses only.

To obtain a claim form call:

Administrative Services Only, Inc, at 1-888-692-7671

What is Covered

You will be entitled to receive long-term disability benefits if you become totally disabled by an accidental injury or sickness while you are covered by the Plan. You must complete a qualifying period of twenty-six consecutive weeks, and you must file for Social Security disability benefits before you begin receiving monthly benefits under this coverage.

If you are continuously and totally disabled, and your eligibility for participation in the Plan is terminated because of loss of payroll status, you remain eligible to receive long-term disability benefits to the maximum permitted by the Plan. Continuation of this coverage is contingent upon verification of your continuous disability as required by the Plan.

How Much

Your monthly benefit while totally disabled will be \$400 per month, less what you receive for that month:

1. from any type of remuneration from the Plan
2. from your employer under any annuity or pension plan
3. from Social Security or Railroad Retirement as a result of disability or retirement
4. as a periodic benefit for your disability from any other employee benefit plan or any government agency or program

You are not required to include payments which began before you were covered by the Plan, unless such payment was increased after you became insured because of a change in the degree of your disability, In that case, you are not required to include the amount of the added payment. in (d) it will be assumed that you are entitled to the largest amount of benefits, including those for dependents. If you are not so entitled, you must submit proof satisfactory to the Plan.

Single Lump Sum Payments Under Other Plans

A lump sum might be paid by other sources in place of periodic payments referred to in "How Much." If so paid, the lump sum will be deemed paid in the amount and for the time which would have applied if there had not been a lump sum payment.

What is Total Disability

You are "totally disabled" if you are unable during the first two years of a period of disability to do all duties pertaining to your work. For the rest of the period you must not be able to do any work for compensation or gain for which you may be reasonably fitted by learning or experience.

You will not be deemed so disabled if you do any work for compensation or gain, or during a period in which you are not under the direct care of a doctor. This direct care starts when the doctor examines you.

Total Disability Due to Accident

This is a disability that:

1. is the result of an accidental bodily injury, directly and independently or all other causes; and
2. occurs within thirty days after the date of the accident.

It will not include any disability described in the paragraph "Some Disabilities Deemed a Sickness." This is a disability that is the result of:

1. sickness or disease; or
2. an injury other than one described in the paragraph "Total Disability Due to Accident."

Some Disabilities Deemed a Sickness

A disability will be deemed due to sickness if it results from:

1. an injury caused or contributed to by disease or bodily infirmity, or
2. disease or infection, or medical or surgical treatment for it.

When Do Benefits Begin And End

Accident Benefits

Monthly benefits will start the day after the waiting period. They will go on as long as you remain totally disabled. You must give proof of such disability that will satisfy the Plan. Benefits will cease on the date you reach the terminating age, which is age 65.

Sickness Benefits

Monthly benefits will start the day after the waiting period. They will go on as long as you remain totally disabled. You must give proof of such disability that will satisfy the Plan. Benefits will cease on the earliest date of anyone of the following:

1. the date twenty-four months of benefits have been payable for anyone period of disability;

2. the date a combined total of twenty-four months of benefits have been payable for two or more periods of total disability due to sickness from related causes;
3. the date you reach the terminating age, which is age 65.

These are treated as follows:

1. If they are due to unrelated causes and separated by your return to active work, they are treated as separated periods.
2. If they are due to related causes:
3. they are treated as separate periods if they are separated by your return to work for at least three months in a row; or
4. they are treated as one period when not so separated.

Only one waiting period will be required for all periods of disability which are treated as one period of disability.

All these periods must begin while you are insured.

Disabilities At The Same Time

Your monthly benefit due to more than one cause will be the same as the rate for one due to a single cause.

Except as described below, you will be paid either accident benefits or sickness benefits during a period of disability. You will not receive both.

You might cease to be disabled due to sickness while sickness benefits are being paid. If this occurs before twenty-four months of benefits have been payable as described in (1.) or (2.) of "Sickness Benefits": benefits will go on if you are still totally disabled due to accident. The benefits will be the same as if you had remained disabled due to such sickness.

You might cease to be disabled due to accident while Accident Benefits are being paid. If this occurs before twenty-four months of benefits have been payable for that disability benefits will go on if you are still totally disabled due to sickness. Benefits will be paid as described in "Sickness Benefits." Benefits for the whole period of disability will not be payable for more than twenty-four months.

Not Covered

No benefits will be paid for disability:

1. due to intentionally self-inflicted injury.
2. due to war, if declared or not.
3. due to, or as a result of taking part in, commission of a felony.

Long-term disability benefits may be terminated if you:

1. fail to provide proof of application for Social Security disability benefits;
2. refuse to supply requested information;
3. refuse to cooperate with an independent medical examination if requested.

WELL BABY/CHILD CARE

Who is Covered

Full and Part-time nurses.

Coverage Limits and What is Covered

\$600 lifetime maximum benefit for each newborn.

Charges for in hospital newborn nursery care and outpatient well baby/child care services furnished to a child from the date of birth and prior to the child's nineteenth birthday or age 23 for full time students. Outpatient well baby/child care will cover:

1. Routine immunizations;
2. Routine well baby/child doctor examinations;
3. X-ray and laboratory services given or ordered at the time of such routine examination, and related to the routine examination

Limitations

Services subject to coverage under the New York State Child Well Baby Care Benefit Mandate for group medical care plans (your NYC Basic Medical Plan)

Claims Procedure

After you have received payment under your base plan, or notice of denial of payment obtain a claim form from Administrative Services Only, Inc and submit a copy of the Explanation of Benefits along with a bill from your physician or hospital to Administrative Services Only, Inc.

OPTICAL PLAN

(Effective April 1, 2009)

Who is Covered

Full Time Nurses and their eligible dependents. Part Time Nurses are also covered; however, there is no dependent coverage for Part Time Nurses.

What is Covered

1. Complete pair of eyeglasses including lenses and frames.
2. Complete pair of eyeglasses with bifocal lenses and frames.
3. Eye examination (refraction test).
4. Tinted glasses where medically indicated. Prescription sunglasses are covered at those participating stores offering this benefit. Please check with Participating Providers before purchasing to determine availability.

Note:

1. Under this plan you and your dependents are entitled to an optical benefit every 24 months.
2. When a non participating store is used, you will be reimbursed a maximum reimbursement of \$100, which includes an eye examination, lenses and frame.
3. When using a participating store there are allowances for services and items that are not fully covered. This includes designer frames, contact lenses and executive bifocals.
4. There are /imitations and restrictions on the number and type of frames covered under the Plan when using a participating store.

How to Use the Benefit

To use the optical benefit call the Member's Services Team at Administrative Services Only, Inc. or visit their website at www.asonet.com and request an optical claim form and a list of participating providers. Present the optical claim form to your participating provider at the time services are rendered. When a non-participating provider is used ask that your provider completes the optical claim form or attach a paid receipt and mail it to Administrative Services Only, Inc.

All glasses supplied under your Optical Plan comply with the recent Food and Drug Administration requirement that all lenses be "impact resistive". This is done for your greater safety and protection.

GRANDFATHERED PLAN

The Fund believes this plan is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a grandfathered health plan means that your plan does not include certain consumer protection of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grand fathered health plan and which might cause a plan to change from grand fathered health plan status can be directed to the Plan administrator at Plan Administrator, 155 Washington Ave, Albany, NY 12210, (518) 782-9400. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov.ebsa.

COBRA

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You could become a qualified beneficiary if you lose coverage under the Plan because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- a. Your hours of employment are reduced, or
- b. Your employment ends for any reason other than your gross misconduct.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Electing COBRA after a Leave under FMLA

If you take a leave of absence under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you will be entitled to elect COBRA if:

You were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and

You will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment or reduction of hours. (See How is COBRA Coverage Provided? on next page).

How is COBRA Coverage Provided?

When the Plan Administrator is notified that one of these events has happened, you will, in turn, be notified that you have the right to choose COBRA continuation coverage. You have 60 days to inform the Plan Administrator that you want continuation coverage. This 60-day election period begins on the later of the date you would lose coverage (due to the qualifying event) or the date the Plan Administrator provides the notice of the right to elect COBRA. A Welfare Plan participant, spouse, or dependent child must notify the Plan of a divorce, legal separation or change in dependent status. This notice must be sent to the Plan within sixty days of the later of either of the following:

1. The date of the qualifying event
2. The date coverage would otherwise be lost

COBRA continuation coverage is a *temporary* continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage for several reasons, which are described below in the item below entitled Termination of COBRA Coverage Before the End of the Maximum Coverage Period.

When the qualifying event is the end of employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for 18 months.

Disability extension of 18-month period of continuation coverage

If you are determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Paying for COBRA Continuation Coverage

You must pay the cost of COBRA continuation coverage. The cost of coverage is determined by the Board of Trustees and is subject to change periodically as the actual cost of providing benefits changes.

Generally, the amount of the premium for COBRA coverage will not exceed 102 percent of the cost of providing benefits to a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will not exceed 150 percent of the cost of coverage.

Your first payment must be made within 45 days of the date that the COBRA election was made. After the initial payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be cancelled retroactively to the first day of the month for which no payment was received and all COBRA rights are forfeited.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

Your continuation coverage may be shortened for any of the following reasons:

1. the Plan no longer provides group health coverage to any of its participants;
2. the premium for your continuation coverage is not paid;
3. you become covered under another group health plan that does not have a pre-existing condition limitation. Even if the other plan's coverage is less valuable than the continuation coverage, continuation coverage will cease; *If the other group health plan has a pre-existing condition limitation, coverage will not end provided the beneficiary provides evidence of the pre-existing limitation from the other group health plan's policy, document or Summary Plan Description.*
4. you become eligible for Medicare;

5. for any reason the Plan would terminate coverage of a participant not receiving continuation coverage (such as fraud).
6. in the case of extended COBRA coverage due to disability: after Social Security determines that you are no longer disabled; or when you become eligible for Medicare (even if it is before the 29 months has expired).

Special Considerations in Deciding Whether to Elect COBRA

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (APBGC) (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free 1-866-626-4282.

More information about the Trade Act is also available at <http://www.doleta.gov/tradeact/benefits.cfm>.

New York State Extension

Notwithstanding anything else foregoing, the Plan will offer 36 months of COBRA continuation coverage to the extent required by New York State law.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S.

Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Plan Contact Information

NYSNA
155 Washington Ave
Albany, NY 12205
(518) 782-9400

NYSNA New York City Office (NYCO)
131 West 33rd Street, 4th Floor
New York, NY 10001
(888) 551-3112 (toll-free)
(212) 785-0157

Administrative Services Only
152 Barrett Street
Schenectady, NY 12305
1-888- 692-7671

FAMILY AND MEDICAL LEAVE RIGHTS

The Family and Medical Leave Act of 1993 (the Act) requires covered Employers to provide up to 12 weeks of unpaid leave to eligible employees for certain family and medical reasons. Employees are considered eligible for this leave if:

1. The employee has worked for the covered Employer for at least 1 year;
2. The employee has worked 1,250 or more hours over the previous 12 months; and
3. There are at least 50 employees within 75 miles of your workplace.

Unpaid leave may be granted to an eligible employee for any of the following reasons:

1. To care for the employee's child after birth, or placement for adoption or foster care;
2. To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
3. For a serious health condition that makes the employee unable to

perform the employee's job.

Note: At the Employer's option, certain kinds of paid leave may be substituted for or used prior to using unpaid leave (i.e., accrued vacation or sick leave). If the Employer does not require the use of the unpaid leave, the employee retains the option of choosing to use paid leave prior to any unpaid leave.

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if the following requirements are not met:

1. The employee ordinarily must provide 30 days advance notice when the leave is foreseeable.
2. An Employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the Employer's expense) and a fitness for duty report to return to work.

The Family and Medical Leave Act also provides job and benefit protection to employees by mandating certain administrative compliances. For example:

1. For the duration of the approved leave, the Employer must maintain the employee's health coverage under any group health plan. If the employee normally makes contributions toward the cost of the group health plan, the Employer may require the employee to continue to make the contributions while on leave. The method and timing of these contributions will be determined by mutual agreement between the Employer and employee.
2. Upon return from the approved leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
3. The use of the approved leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.
4. The Family and Medical Leave makes it unlawful for any Employer to:
 - a. interfere with, restrain, or deny the exercise of any right provided under the Act;
 - b. discharge or discriminate against any person for opposing any practice made unlawful by the Act or for involvement in any proceeding under or relating to the Act.

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations under the Act. An eligible employee may bring a civil action against an Employer for violation.

This Act does not affect any Federal or State law prohibiting discrimination, or supersede any State or Local law or Collective Bargaining Agreement, which provides greater family, or medical leave rights.

For Additional Information: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor, or the office of the Plan Administrator.

BENEFITS WHILE ON MILITARY LEAVE

If you enter the United States armed forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your health coverage under the Plan during your military service for a period of up to 18 months under the federal law, the Uniformed Services Employment and Reemployment Rights Act (AUSERRA). If your military service exceeds 31 days, you may be charged the applicable COBRA premium.

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage reinstated when you return to employment following honorable discharge, provided that you return to employment within the time periods prescribed by law. No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury connected with your military service. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

CHANGE TO THIS SPD

No person other than the Board of Trustees is authorized to:

1. change or amend this SPD
2. waive any condition or restriction contained in this SPD,
3. extend the time for making any contribution or payment, or
4. bind the Plan by any statement or promise.

No change in this SPD will be valid unless authorized by the Board of Trustees. Nothing contained in this SPD shall limit the broad discretion of the Plan Administrator, Board of Trustees and Independent Fiduciary to interpret and apply the provisions of this SPD or the terms of the Plan.

EXAMINATION OF CLAIMS

The Plan has the right and opportunity to examine and investigate, at its expense, the person whose injury or sickness is the basis of the claim, when and so often as it may reasonably require during pendency of the claim under this SPD.

You or your personal representative or any other claimant must promptly furnish all consents and authorizations upon request of the Plan to permit its designated representatives to examine any and all medical, hospital, and other privileged records and communications relating to any claim filed under this SPD.

ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan 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, a copy of the latest annual report (Form 5500 Series), if any, 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 copies of the latest annual report, if any, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on 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 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 plan documents or the latest annual report from the Plan, if any, and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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 courts costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PRIVACY RIGHTS UNDER HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, as amended by the Health Information Technology for Clinical and Economic Health Act (AHITECH), requires Covered Entities to take specific steps to safeguard individuals' Protected Health Information (PHI) and to notify individuals of their rights to control the use and disclosure of their PHI.

Your Rights Regarding Your Medical Information

You have the right to inspect and copy your medical information, to request corrections of your medical information and to obtain an accounting of certain disclosures of your medical information.

Summary of Privacy Practices

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by the Plan or others in the administration of your claims, and certain rights that you have. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the Notice of Privacy Practices below.

Our Pledge Regarding Medical Information

We are committed to protecting your personal health information. We are required by law to:

1. make sure that any medical information that identifies you is kept private,
2. provide you with certain rights with respect to your medical information,
3. give you a notice of our legal duties and privacy practices, and (4) follow all privacy practices and procedures currently in effect.

How We May Use and Disclose Medical Information About You

We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment for any medical treatments, and for any other health care operation. We will disclose your medical information to Plan Trustees and for Plan administration purposes. We may also use and disclose your protected health information without your permission as allowed or required by law. We must obtain your written authorization for any other use and disclosure of your medical information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization given previously.

How to File Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Office for Civil Rights. We will not retaliate against you for making a complaint.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes the legal obligations of the NYSNA Welfare Fund for NYC Employed Registered Professional Nurses and your legal rights regarding your protected health information obtained by the Plan. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices ("Notice") to you pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The HIPAA Privacy Rule protects only certain medical information known as protected health information. Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to:

1. your past, present or future physical or mental health or condition,
2. the provision of health care to you, or
3. the past, present or future payment for the provision of health care to you.

This Notice is effective January 1, 2015. If you have questions about this Notice or about our privacy practices, please contact the Plan Administrator at (518) 782-9400.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of this Notice that is currently in effect. Furthermore, we are required to notify you if your protected health information has been breached.

We reserve the right to change the terms of this Notice as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice, mailed to your last known address on file.

How We May Use and Disclose Your Protected Health Information

The law permits us to use or disclose your protected health information without your permission in the following cases:

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers, including doctors, nurses or other hospital personnel who are involved in taking care of you. Such disclosures will usually be made by the insurance company paying or administering the benefits, or by the Plan. For example, the Plan may disclose the name of your treating physician to a treating orthopedist so that the orthopedist can obtain your x-rays from your physician.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, or to coordinate Plan coverage. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. Such disclosures will usually be made by the insurance company paying or administering the benefits or by the Plan.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

For Health Care Operations. We may use or disclose your protected health information for other Plan operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, creating or renewing insurance contracts, underwriting, premium rating and other activities related to Plan coverage. This may include submitting claims for stop-loss coverage, disease management, case management, conducting or arranging for medical review, audit services including fraud and abuse detection programs, business management and general administrative activities. We will not use or disclose your protected health information that is genetic information for underwriting purposes.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to provide support services, such as utilization management or subrogation.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use or disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Trustees. For Plan administration purposes, we may disclose protected health information to the Plan Trustees. However, those individuals will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. For example, we may disclose information to the Plan Trustees to allow them to decide a claim appeal.

Treatment Alternatives. We may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or transplantation, as necessary to facilitate donation or transplantation.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs providing benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions, including prevention or control of disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting

reactions to medications or problems with products; notification to affected individuals of recalls of products; notification to affected individuals of exposure to a disease or increased risk for contracting or spreading a disease or condition; notification to appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this last disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order; for example, in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime, if under certain limited circumstances, we are unable to obtain the victim's agreement; about a death that we believe may be the result of criminal conduct; and about criminal conduct.

Coroners, Medical Examiners, Funeral Directors. We may release protected health information to a coroner or medical examiner; for example, to identify a deceased person or determine cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or are in the custody of law enforcement officials, we may disclose your protected health information if necessary for the institution to provide you with health care or to protect your health and safety or the health and safety of others.

Research. We may disclose your protected health information to researchers when the individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established privacy protocols and has approved the research.

Required Disclosures

We are required to make the following disclosures:

Government Audit. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule. **Disclosures to You.** When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Although the Plan does not routinely sell PHI or use it for marketing purposes, it must obtain your written authorization before it may sell your PHI or use it for marketing purposes.

All Other Disclosures

Personal Representatives. As permitted by law, we will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, so long as you provide us with a written authorization and any supporting documents (i.e. power of attorney).

Restrictions. With only limited exceptions, we will send all mail to your last known address on file. If a person has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses and disclosures of your protected health information not elsewhere described in this Notice will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Your written revocation, once received by us, will only be effective for future uses and disclosures.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have a right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy such information, you must submit your request in writing to:

NYSNA
Plan Administrator
155 Washington Ave
Albany, NY12210
(518) 782-9400

If you request a copy of the information, we may charge a reasonable fee for providing the information. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan's Privacy Official.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan's Privacy Official, whose contact information appears in the preceding paragraph. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that is not part of the medical information kept by or for the Plan; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect or copy; or is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include:

1. disclosures for purposes of treatment, payment or health care operations,
2. disclosures made to you,
3. disclosures made pursuant to your authorization,
4. disclosures made to friends or family in your presence or because of an emergency,
5. disclosures for national security purposes, or
6. disclosures incidental to otherwise permissible disclosures.

To request an account of disclosures, you must submit your request in writing to the Plan's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights. " Your request must state a time period of no longer than six years. Your request should indicate in what form you want the information (i.e. paper or electronic). The first request you make for an accounting within a twelve-month period will be provided free of charge. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment or health care operations, or that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could request that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree, we will honor the restriction until you revoke it or we notify you. To request a restriction, you must make your request in writing to the Plan's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights." In your request, you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

The Plan, however, is not required to agree to your request except if the use or disclosure is for purposes of carrying out payment or health care operations, is not otherwise required by law, and the PHI pertains solely to a health care item or service that has been paid for in full by you or somebody other than the Plan.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your

request in writing to the Plan's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights." We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice from us at any time, even if you have agreed to receive the Notice electronically. You may request a copy by contacting the Plan's Privacy Official, whose contact information appears in the first paragraph of this section entitled Your Rights.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact: Plan Administrator, 155 Washington Ave, Albany, NY 12210, (518) 782-9400. All complaints must be submitted in writing. You will not be penalized, or in any way retaliated against, for filing a complaint with the Office of Civil Rights or with us.

Security of Protected Health Information

The Security Rule of HIPAA provides procedures to safeguard your Electronic Protected Health Information. Electronic Protected Health Information is defined in government regulations and generally is any Protected Health Information that is created, received, maintained, or transmitted in electronic form. If any other provision(s) of this booklet conflicts with the requirements of this section, this section will control.

The Plan will safeguard Electronic Protected Health Information by:

1. *Administrative, Physical, and Technical Safeguards.* Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information the Plan creates, receives, maintains, or transmits on behalf of the Plan.

2. *Security of Adequate Separation.* Ensuring that the Adequate Separation between:
 - a. the Plan and other offices or plans of the Union or employers described in the Privacy of Protected Health Information Section is supported by reasonable and appropriate security measures.
3. *Subcontractors and Agents.* Ensuring that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.
4. *Reporting.* Reporting to the security official of the Plan or the security official's designee any Security Incident of which it becomes aware.

These requirements do not apply to Electronic Protected Health Information that the Plan receives pursuant to an appropriate authorization that complies with HIPAA regulations or that qualifies as A Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending, or terminating the Plan as authorized by the HIPAA Privacy Rules. Summary Health Information is defined in HIPAA regulations and generally is claims data for the Plan from which most information that could be used to identify you individually is removed.