NYSNA Benefits Fund

2011 Summary Material Modification

December 2011

The following Summary Material Modification reflects changes made to the NYSNA Benefits Fund since the Fund published its most recent Summary Plan Description in 2008. This comprehensive document includes two previous Summary Material Modifications, which outlined changes regarding:

- **Dental Care** (2009 SMM)
- **Eligibility and COBRA** (2010 SMM) – Due to changes in dependent eligibility, the portion of the Summary Material Modification related to Michelle's Law is no longer applicable to the Benefits Fund and has been removed effective September 1, 2011.

This Summary Material Modification also replaces or restates some sections of the 2011 Summary Material Modification (Eligibility, elimination of lifetime benefit limit, and change to Oxford) dated January 2011 to reflect the following changes applied to the Benefits Fund this year.

Elimination of lifetime benefit limit – There is no longer an annual or lifetime limit on out-of-network benefits.

Change to Oxford Health Insurance – Effective January 1, 2011, the Fund's medical care provider is Oxford Health Insurance Inc., a UnitedHealthcare company.

Cost sharing – Due to Benefits Fund Plan changes, participants will share in the cost of their Fund coverage by making payroll deduction contributions through their employers.

Open enrollment – The Fund's open enrollment period has been consolidated into a one-time period between November 1 and December 31.

Opt-out provision – Full-time participants have the opportunity to opt out of the Fund for themselves, their spouses, and all of their dependents, or only their dependents and spouse.

Opt-in – Participants who opted out of coverage may re-enroll in the Fund within 60 days of a qualifying life event with coverage retroactive to the date of the qualifying event or wait until open enrollment.

Same-sex domestic partner eligibility – Same-sex domestic partners and their dependent children who have had Fund coverage prior to November 1, 2011, will lose eligibility beginning July 1, 2012, unless the same-sex domestic partners get married. No new same-sex domestic partners (or their dependent children) are eligible for Fund coverage effective November 1, 2011.

In addition, as of September 1, 2011, the Benefits Fund's mental health care and substance abuse/alcohol addiction benefits will be the same as any other physical health benefits provided by the Fund due to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. This means there are no longer limitations on frequency of treatment, number of visits, or days of coverage, and coverage is no longer limited to non-biolgocally based diagnoses for mental disorders. Furthermore, this change nullifies the Fund document titled "In-Network Mental Health Parity Amendment to SPD" with an effective date of January 1, 2007.

New York State Nurses Association

NYSNA Benefits Fund

PO Box 12430 • Albany, NY 12212-2430
PHONE (877) RN BENEFITS
FAX (518) 869-9529
www.rnbenefits.org

New York State Nurses Association
NYSNA Benefits Fund
PO Box 12430 • Albany, NY 12212-2430 • (877) RN BENEFITS

2009 SMM

Aetna has refiled with the New York State Department of Insurance the following change to its "Definitions" since the Benefits Fund published its most recent* Summary Plan Description *in 2008. Please keep this information with the* Summary Plan Description *you received in 2008 or when you became a participant of the NYSNA Benefits Fund.

Under the "Definitions" section, beginning on Page 46, new definitions and new terms have been added, while some existing terms are no longer in use.

Terms that are no longer in use and should be removed from "Definitions" between Pages 46 and 47 are:

- Preferred care provider
- Non-preferred care
- Preferred care
- Necessary
- Reasonable charge.

Terms with new definitions are:

• **Hospital** – An institution that is primarily engaged in providing, on its premises, inpatient medical, surgical, and diagnostic services; is supervised by a staff of physicians; provides 24-hour-a-day RN service; charges patients for its services; and operates in accordance with the laws of the jurisdiction in which it is located.

An institution may still be defined as a hospital if it does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent home or any institution or part of one that is used primarily as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

• **Physician** – A duly licensed member of a medical profession who has an MD or DO degree; is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; and provides medical services that are within the scope of her license or certificate.

This also includes a health professional who: is properly licensed or certified to provide medical care under the laws of the jurisdiction where he practices; provides medical services that are within the scope of her license or certificate; under applicable insurance law, is considered a "physician" for purposes of this coverage; has the medical training and clinical expertise suitable to treat your condition; specializes in psychiatry if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse, or a mental disorder; and is not you or related to you.

New terms to add within the "Definitions" section of the Summary Plan Description on Pages 46 and 47 are:

• **Dental provider** – Any dentist, group, organization, dental facility, or other institution or person legally qualified to furnish dental services or supplies.

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

– In accordance with generally accepted standards of dental practice;

– Clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease;

– Not primarily for the convenience of the patient, physician, other health care, or dental provider;

– Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical or dental practice" means standards based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with

physician or dental specialty society recommendations, and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

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

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

• **Out-of-network provider** – A dental provider who has not contracted with Aetna to furnish services or supplies at a negotiated charge.

• **Recognized charge** – Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:

– The provider's usual charge for furnishing it;

– The charge Aetna determines to be appropriate based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed, or coded; or the provider charge data from the Prevailing HealthCare Charges System at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months;

– The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is unusual; or not often provided in the geographic area; or provided by only a small number of providers in the geographic area, Aetna may take into account factors such as the:

– Complexity,

– Degree of skill needed,

– Type of specialty of the provider,

– Range of services or supplies provided by a facility,

– Recognized charge in other geographic areas.

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

As used above, the term "geographic area" means a Prevailing HealthCare Charges System expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service ZIP Codes. If the volume of charges in a single three-digit ZIP Code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit ZIP Code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit ZIP Codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit ZIP Codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are used.

• **Specialist dentist** – Any dentist who, by virtue of advanced training, is board-eligible or certified by a specialty board as being qualified to practice in a special field of dentistry.

Aetna also has clarified and provided additional information to some provisions of its dental care coverage since the Benefits Fund published its most recent* Summary Plan Description *in 2008.

Covered services

Additional information has been provided to clarify the first bullet point on Page 37 under "Type A expenses (diagnostic and preventive)" to read: Periodontal maintenance procedures (eligible with no history or surgery required and limited to two per year; limit is combined with the prophylaxis frequency).

The following additional information should be included after the last bullet item on Page 40 under the Prosthodontics section of "Type C expenses (major):"

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

– While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.

– The present crown, inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable.

– You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one, which replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date the temporary denture was installed.

• The "Missing Tooth and Not Replaced" rule does not apply to the dental plan. The dentures, bridges, or other prosthetic services needed to replace one or more natural teeth that were removed prior to becoming a participant in the plan will be covered.

2010 SMM

Please add the following Summary Material Modification to the Eligibility section (Chapter 6) of your* Summary Plan Description. *Its effective date is January 1, 2010.

New York's new provision of the New York State Insurance Law allowing health insurance coverage for unmarried young adults through age 29 requires health insurance providers to allow an unmarried child of an insured employee to obtain or continue *medical insurance coverage only* through age 29 without regard to financial dependence.

The dependent child must be unmarried, 29 years of age or under, live, work, or reside in the State of New York or the service area of the insurer (Health Net for Fund participants), and must not be insured by or eligible for any other employer-sponsored medical plan or be covered by Medicare. *There is a separate premium for this coverage, which the dependent child or parent must pay.*

This coverage may be elected when a child ceases to be an eligible dependent under the plan due to reaching the maximum age for dependent coverage (end of the year in which he or she turns age 19 or, if a full-time student, end of the year in which he or she turns age 23).

To enroll, the dependent or parent should notify the Fund in writing and include payment of the first month's required premium. The child has 60 days from termination of coverage or during an open enrollment period to elect the extension.

When the child no longer satisfies eligibility requirements or is more than 30 days late paying the premium, coverage ends.

Please add the following Summary Material Modification to the COBRA section in Chapter 8 of your* Summary Plan Description. *Its effective date is January 1, 2010.

New York's 36 month state continuation benefit permits a person who is an employee or member of a group to continue group health insurance for up to 36 months, regardless of the reason that the person lost eligibility for coverage.

Specifically, this law extends the state's existing continuation coverage statute (also known as mini-COBRA) to 36 months from its previous 18-month period and provides a state continuation benefit that extends the continuation period for an employee or dependent receiving federal COBRA coverage by permitting them to receive mini-COBRA coverage upon termination of federal COBRA coverage.

Previously, the mini-COBRA statute only covered insured plans if the employer employed fewer than 20 people. Now, all employers who offer insurance, regardless of their size,

must make continuation coverage of their fully insured benefits available to New York employees for up to 36 months following the date of the qualifying loss of coverage (for Fund coverage, this means *medical only)*.

This change will require that an additional 18 months of continuation coverage be provided under New York mini-COBRA once 18 months of federal COBRA is exhausted. RNs who are on disability and have 29 months of COBRA eligibility now have an addtional seven months.

2011 SMM

Please add the following Summary Material Modification to the Eligibility section (Chapter 6) of your **Summary Plan Description.** ***This information replaces the Eligibility section starting with the subsection titled Full-time employees effective date on Page 24 through the Part-time employees subsection on Page 25 and is effective November 1, 2011.***

FULL-TIME EMPLOYEES

Effective date

Your coverage will become effective on your eligibility date, provided you authorize payroll deductions by your employer. To check your eligibility date, find your facility listed in Chapter 1 of this book. The criteria used to determine your eligibility date appear beside it.

Cost sharing

You are responsible for sharing the cost of your Benefits Fund coverage with your employer by making payroll deduction contributions as outlined in the first collective bargaining agreement containing an Employee Premium Option ratified after September 1, 2011.

Upon enrollment in the Benefits Fund, you will be required to sign a payroll deduction form (available at your place of employment) authorizing your employer to make payroll deductions as stipulated in the collective bargaining agreement. Should you fail to sign a payroll deduction form, you will not be eligible to participate in the Benefits Fund at this time and must wait until the annual open enrollment period between November 1 and December 31 to enroll.

Opting out of coverage

You may be employed at a participating employer under a collective bargaining agreement that allows an otherwise eligible participant to opt out of Benefits Fund health coverage if she is covered under another group health plan. This information is available in your NYSNA contract.

Full-time employees at a facility that permits opting out have the right to opt out of health benefit coverage for:

• yourself and all of your dependents and spouse, or

• only your dependents and spouse

as long as you and your dependents and spouse are covered under another group health plan. You will be required to provide proof of other coverage and complete an opt-out application available at your place of employment within 60 days of your date of hire. If you opt out, you will continue to be covered by the Fund for disability, life, and accidental death and dismemberment benefits.

If you choose to opt out of health coverage at the time of eligibility, you and your dependents (including your spouse) must wait until the annual November 1 through December 31 open enrollment period to re-enroll in the Benefits Fund and have coverage reinstated effective January 1 of the following year.

If you decline enrollment for yourself and your dependents (including your spouse) because you have other health insurance coverage (medical, dental, vision, and prescription drug), you may in the future be able to enroll yourself and your dependents (including your spouse) in this plan, provided you request enrollment within 60 days after your other coverage ends due to the following:

• Death of the covered individual (death certificate and COBRA notification or letter from the covered individual's employer must be provided within 60 days of the event).

• Termination of employment or reduction of hours that would cause loss of coverage for the covered individual (COBRA notification or letter from the covered individual's employer must be provided with 60 days of the event).

• Divorce or legal separation from the covered individual, causing a loss of coverage (a copy of the divorce or

legal separation decree must be provided within 60 days of the event).

• Covered individual's employer discontinues group health insurance coverage (a letter or notification from the covered individual's employer must be provided within 60 days of the event).

For purposes of this explanation, the "covered individual" is the person who currently provides the coverage.

All other reasons for losing coverage (including the covered individual voluntarily discontinuing coverage or failing to make required payments) will not be considered.

PART-TIME EMPLOYEES

Eligibility

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

Cost sharing

You will be required to make payroll deduction contributions toward the cost of your coverage as defined in the current collective bargaining agreement.

Opting out of coverage

You have the right to discontinue coverage at any time. If you choose not to enroll at the time of eligibility or to discontinue coverage, you must wait until the annual open enrollment period between November 1 and December 31 of any plan year to re-enroll in the Benefits Fund and have coverage reinstated January 1 of the following year.

If you decline coverage for yourself and your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself and your dependents in the plan, provided you request enrollment within 60 days after your other coverage ends for any of the reasons previously stated in the Full-time employee section.

Open enrollment

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

Individuals who are eligible to enroll during the annual open enrollment period include:

• Full- or part-time employees who previously opted out of Benefits Fund coverage,

• Dependents who were not added when they first became eligible.

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

Due to the passage of New York state's Marriage Equality Act in June 2011, changes have been made to the eligibility for same-sex domestic partners and their eligible dependents. In addition, changes have been made to the procedure for adding a newly eligible dependent to your Benefits Fund coverage. The following information, therefore, replaces the Eligible dependents section of the 2011 **Summary Material Modification** ***(Eligibility, elimination of lifetime benefits, and change to Oxford) effective November 1, 2011. The Full-time college students subsection will be eliminated effective July 1, 2012.***

Eligible dependents

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

• Your spouse is eligible for medical, dental, vision, and prescription drug benefits through the Benefits Fund.

• Your same-sex domestic partner who has been a covered dependent on or before October 31, 2011, remains eligible for medical, dental, vision, and prescription drug benefits until July 1, 2012 (please see information below regarding same-sex domestic partner eligibility).

• Your children, stepchildren, foster children, and legal wards also are eligible for medical, dental, vision, and prescription drug benefits from birth until their 26th birthday.

• Dependent children living with you while awaiting your legal adop-

tion are eligible for these benefits until their 26th birthday.

• Through June 30, 2012, dependent children of your same-sex domestic partner who are Benefits Fund participants as of October 31, 2011, are eligible for coverage until December 31 of the year in which they turn age 19 or until December 31 of the year they turn 23 if they are full-time students (please see information below regarding same-sex domestic partner eligibility).

If you don't have a dependent now, you will become eligible for dependent coverage on the day you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided you request enrollment within 60 days of the marriage, birth, adoption, or placement for adoption. If notification of a new dependent is not received within 60 days of the marriage, birth, adoption, or placement for adoption, the dependent will need to wait until the next open enrollment period between November 1 and December 31 to be eligible for the Benefits Fund with an effective date of January 1 of the following year.

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

Stepchildren

Stepchildren are eligible for medical, dental, vision, and prescription drug coverage until they reach their 26th birthday. Birth and marriage certificates are required by the Fund office for documentation.

Foster children and legal wards

Foster children and legal wards under your custody or guardianship are covered until they reach age 26. To effect coverage for legal wards, the participant must submit a copy of the ward's birth certificate and a certified copy of the guardianship or custody appointment.

Same-sex domestic partner

Effective November 1, 2011, no new same-sex domestic partners will be eligible for Benefits Fund coverage. Same-sex domestic partners and dependent children of same-sex domestic partners who are currently receiving benefits through the Fund will no longer be covered for medical, dental, vision, and prescription drug benefits effective July 1, 2012.

Disabled dependents

Coverage for any of your unmarried children who are disabled and incapable of earning their own living will be extended beyond the 26-year age limit. In this case, you must notify the Benefits Fund and submit proof of your child's disability within 60 days after the coverage would otherwise cease. For information, contact the Benefits Fund. Proof of the disability must be updated as applicable.

Qualified Medical Child Support Order

The Fund will comply with the terms of any Qualified Medical Child Support Order, as the term is defined in the amended Employee Retirement Income Security Act of 1974.

In general, a QMCSO is a state order or administrative directive requiring a parent to provide medical support to a child in case of separation or divorce and under certain statutory conditions.

A QMCSO may require the Fund to offer coverage to your child even though the child is not, for income tax purposes or Fund purposes, your legal dependent due to separation or divorce.

A Qualified Medical Child Support Order must:

• Be issued by a court or an administrative agency (under certain circumstances),

• Clearly specify the alternate recipient,

• Reasonably describe the type of coverage to be provided to such alternate recipient, and

• Clearly state the period to which such order applies.

Upon receipt of a medical child support order, the Benefits Fund will notify you and the affected child that it is reviewing the order to determine if it is qualified and will explain the procedures used to determine whether the order is

qualified.

The plan administrator will determine the qualified status of a medical child support order in accordance with the Fund's written procedures.

Participants and beneficiaries can obtain, without charge, a copy of these procedures from the plan administrator.

Please add the following Summary Material Modification to the Summary of Benefits section (Chapter 4) of your Summary Plan Description. It is effective January 1, 2011.

As of January 1, 2011, there will no longer be an annual or lifetime limit on out-of- network benefits. If you had previously met the lifetime or annual out-of-network limit, you will once again have out-of-network coverage starting January 1.

Effective January 1, 2011, the NYSNA Benefits Fund has a new medical care provider, Oxford Health Insurance Inc., a United-Healthcare company, to replace Health Net. Please note the following changes to the* Summary Plan Description *you received in 2008 or when you became a participant of the Benefits Fund.

Please replace any mention of "Health Net" with "Oxford Health Insurance Inc, a UnitedHealthcare company" wherever it is found within your *Summary Plan Description*.

In addition, under the "Fund administration" section on Page 8, the reference to Health Net should be removed and replaced with Oxford Health Plans, 48 Monroe Turnpike, Trumbull, CT, 06611, (203) 459-6000. The Fund provides medical coverage to participants under an insured plan with Oxford Health Insurance Inc., a United-Healthcare company.