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# WELFARE FUND BENEFITS

Revised July 1, 2012

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| **Superimposed Major Medical**<br>**Medical/Hospital**<br>**Prescription Drugs**<br>**Dental** | **Michelle Rivas**<br>**(212) 686-1229**<br>**or S.I.D.S.**<br>**(800) 537-1238**<br>**(718) 204-7172**<br>**(516) 396-5500** |
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| **COBRA**<br>**Young Adult Dependent Coverage** | **Yolanda Milanes**<br>**Vojna Stanic-Geraghty**<br>**(212) 686-1229** |
| **Optical Claims** | **Rose Collins**<br>**(212) 686-1229**<br>**or DavisVision**<br>**(800) 999-5431**<br>www.davisvision.com<br>Contact Davis Vision by phone or on the web for a full list of providers |
| **Life Insurance** | **Diana Caroll**<br>**(212)686-1229** |
| **Medicare Drug Rider** | **Vojna Stanic-Geraghty**<br>**(212) 686-1229** |
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## 2012 EDITION

**There are several significant improvements in the dental coverage portion of your Welfare Fund benefits for 2012. The Trustees have increased the annual maximum dental benefit from $3,000 to $4,000 per person. As of July 1, 2012, you may now have two implants per year, anywhere in your mouth, up to a lifetime limit of six implants. Previously, you were entitled to one implant per year up to a maximum of four in a lifetime, anywhere in your mouth. In addition, the lifetime orthodontic benefit has been raised from $2,500 to $4,000 and orthodontic coverage will now become a separate benefit outside of the fund's coverage for other dental work. In other words, you could, if you chose to do so, make use of your entire lifetime allotment ($4,000) of orthodontic coverage in a given year and still have up to $4,000 worth of other dental services in that same year. – *The Trustees***

# I. MEMBERSHIP

You are entitled to membership in the **OSAWelfare Fund (OSAWF)** if you are an active employee in a title covered by the **Organization of Staff Analysts'** contract and are being paid by your employer for at least 17½ hours of work per week or if you have retired from an **Organization of Staff Analysts'** covered title.

Your membership begins when the employer makes a contractual Welfare Fund payment on your behalf and ceases when the employer no longer makes those payments. The employer will ordinarily terminate your membership when you change to a title not covered by the **Organization of Staff Analysts'** contract, when you leave City Service without retiring, when you leave payroll, when you are being paid for less than 17½ hours per week as an active employee, or when you die. Under certain circumstances, your coverage, or your dependents' coverage may be extended after membership ceases (see section VII – Survivors' Benefits and section VIII – COBRA).

Occasionally, when you first join our union, the employer is slow in making the first payment to the Welfare Fund and you may find you have problems in obtaining Welfare Fund services. If so, please contact the Welfare Fund and let us know immediately. We will make every effort to assist you in resolving the problem and establishing your membership rights.

Your eligible dependents are your spouse/domestic partner and, in many cases, your dependent children. In response to the national health insurance reform bill signed into law in March of 2010 and the 2009 New York State "Age 29" law, your dependent children may continue to be covered by the OSA Welfare Fund up to age 26 (under the federal law) and/or up to age 30 (under the NYS law). For information, please see the section on "Young Adult Dependent Coverage" on page 15.

## IMPORTANT TERMS

- **Deductible:** In insurance terms, a deductible is generally an amount that the insurer will not pay. Usually, it specifies the amount that has to be spent by you, before the insurer assumes any liability.

- **Reasonable and Customary:** Refers to medical or dental expenses which are appropriate to the medical problem, are not for experimental procedures, and which are close to the average charges for the procedure based on a survey of doctors' fees in the area. It is possible that your practitioner could charge more than the "reasonable and customary" charges for his/her geographical area. When this occurs, **the share** of his/her charges **in excess** of the "reasonable and customary" amount will be entirely yours.

- **Out-Of-Pocket Expenses**: Refers to those medical expenses for which you have advanced your own funds and which remain unreimbursed after submission to your basic health insurance plan for coverage.

- **Primary Insurer:** If you are covered by more than one insurer, those insurers are ranked to determine their order of responsibility for reimbursement of your expense. Your primary insurance goes first, applies its rules, and pays accordingly. Your secondary insurance goes next, and so on. For medical expenses, your City health plan is your primary insurer. Your secondary insurer on medical expenses is usually the Superimposed Major Medical Plan (SMMP) of OSA's Welfare Fund, although, in some circumstances, OSA's SMMP becomes tertiary. If you have waived the City's basic health insurance plan because your spouse's insurance covers you or you receive coverage from another employer, then that other insurance becomes your primary insurer.

- **Benefit Year:** The benefit year is the period during which claims and deductibles are calculated. Each benefit year starts with a new deductible. For superimposed major medical claims the benefit year is January 1-December 31, for dental claims it is July 1-June 30 and for optical claims, the benefit year is March 1 - February 28.

- **Family:** You, your spouse and your eligible dependents. For domestic partners, see Section XI**.**

# II. HEALTH INSURANCE

**Benefit year : January 1 - December 31**

## A. SUPERIMPOSED MAJOR MEDICAL PLAN

The Superimposed Major Medical Plan (SMMP) is a supplement to the basic health insurance provided through your employer. It is intended to protect you from extraordinary financial losses resulting from demanding medical conditions. To take full advantage of SMMP's benefits, you **certainly should** have a primary health insurer, and you must make sure your basic health insurance covers prescription drugs. For New York City employees, this means you should select what is called the "Optional Rider" for the basic health insurance plan you choose. If your family is covered by more than one basic health insurance plan, please make sure that at least one of those plans contains a prescription drug plan that covers all members of the family.

### 1. MEDICAL & HOSPITAL

After your out-of-pocket medical and hospital expenses (above and beyond that covered by your basic medical insurance plan) exceed the appropriate deductible amount in the box on page four, the SMMP will provide 90% of your "reasonable and customary" medical and hospital expenses and, after meeting a threshold explained on page five, 100% of your "reasonable and customary" medical and hospital expenses, either by reimbursing you for your expenses, or by making payments to your medical provider.

Some of the medical expenses covered are: co-payments to your doctors and pharmacists, new baby care and wellness visits, hospital emergency room visits and stays, ambulance service, health aide visits, immunizations, prosthetic appliances, medical equipment rentals, and nursing service. Positron Emission Tomography (PET) scans are covered, provided the physician refers you for the test. There are various limitations and restrictions. Since you must generally follow the rules of your primary medical plan, certain treatments may not be covered, and there might be limits to specific services. If services are not covered at all by your primary plan, they might not be covered by the SMMP. An example – if you belong to an HMO and use an out-of-network provider, this service might not be covered.

### 2. PRESCRIPTION DRUGS

For active employees and non-Medicare retirees, prescription drugs *are* a part of Superimposed Major Medical Plan coverage, and are reimbursed at an 80% rate. You must follow the rules of your primary health insurer. Your drug co-payments or those portions of your prescription drug costs which are not paid for by the primary insurer may be submitted for coverage by SMMP. As you can see in the table of deductibles on page four, you should carry a prescription drug rider as a part of your Primary Health Insurance, in order to qualify for the lowest SMMP deductibles.

Those deductibles do not apply to Medicare-eligible retirees. Prescription drugs for these retirees are only a part of Superimposed Major Medical Plan coverage once $4,700 in true out-of-pocket drug expenses are incurred.

#### PICA DRUGS

The Citywide PICA drug program was modified as of July 1, 2005. Only injectable and chemotherapeutic drugs for active employees and non-Medicare retirees and eligible dependents are now provided, regardless of the primary insurer and drug rider which you have chosen. ***Psychotropic and asthma drugs are no longer covered under this program.*** Instead, coverage for these drugs was transferred back to your drug rider on your basic health insurance.

You should have received a plastic PICA drug card and notification from your primary insurer about how their drug rider will be affected by the card. Until you are sure that your medications are not in the injectable or chemotherapeutic categories, you should take the card with you to show to your pharmacist.

There will be a co-payment, which may be a part of your SMMP claim. *Medicare-eligible retirees will not receive the PICA card.*

The PICA benefit is subject to a three-tier co-pay structure for generic, preferred and non-preferred drugs; mandatory mail order for maintenance drugs, the requirement of prior authorization for certain medications, step therapy for certain classes of drugs, preference for generic equivalents, lifetime limits on fertility drugs, and specialty care pharmacy services for certain injectable drugs not covered by your health plan.

There is a $100 annual deductible for injectable and chemotherapeutic drugs.

If you have questions about injectable and chemotherapeutic drugs or need a PICA program card, you may call Express Scripts' Customer Service at (800) 467-2006 or visit their website at www.express-scripts.com. Information is also available on www.osaunion.org. Go to *Members Services* and click on *Welfare Fund Benefits.*

### DRUG BENEFIT FOR MEDICARE-ELIGIBLE RETIREES

The OSA Welfare Fund will pay up to $50 per month toward the cost of drug rider premiums for City-approved health plans for Medicare-eligible retirees and their spouses/domestic partners.

For Medicare-eligible retirees in GHI who are enrolled in a drug rider, the pension deduction for the drug rider premium will be reduced by $50/month for the retiree and $50/month for their covered spouse or domestic partner. For these Medicare-eligibles, the OSA Welfare Fund pays the reimbursement directly to the City's Health Benefits Program.

For Medicare-eligible retirees in any health plan other than GHI who are enrolled in a drug rider, reimbursement will be made annually in a single lump-sum payment of up to $600 per member and covered spouse/domestic partner, prorated if the member was Medicare-eligible for less than the full calendar year. The payment will be made directly to the member by the OSA Welfare Fund early in the following calendar year. Forms and proofs of coverage are required only for those with family drug rider coverage.

**Retired Medicare-eligible** members and/or their spouses/domestic partners are eligible for reimbursement under this program **if their City health plan coverage is provided through a qualified Medicare HMO or GHI and they are enrolled in Medicare Parts A&B.**

In addition, when Medicare-eligible retirees' true out-of-pocket drug expenses exceed $4,700, 100% of additional drug costs become eligible for reimbursement. Your basic health plan drug rider will cover 95% of drug expenses and you will be responsible for the remaining 5%. You may then submit proof of payment for that 5% share to the OSA Welfare Fund for 100% reimbursement under the SMMP.

If you have questions about the drug benefit for Medicare-eligible retirees, please call Vojna Stanic-Geraghty at the union office at (212) 686-1229.

## DEDUCTIBLES

| | **Maximum family deductibles** | | |
|---|---|---|---|
| **If your Basic Medical Coverage includes:** | One Individual | Two Individuals | 3 or more |
| Prescription Drug Rider | $ 500 | $ 1,000 | $ 1,500 |
| Without Prescription Drug Rider | $ 2,000 | $ 4,000 | $ 6,000 |
| No Basic (Primary) Health Plan | $ 10,000 | $ 20,000 | $ 30,000 |

*Members and retirees and each of their dependents are subject to separate deductibles*. An aggregate family maximum will be applied for families consisting of three or more individuals. As a result, the $500 per individual deductible is subject to a $1,500 per family maximum, the $2,000 per individual deductible is subject to a $6,000 per family maximum and the $10,000 per individual deductible is subject to a $30,000 per family maximum. The deductible will not be applied to out-of-pocket expenses (such as co-pays) for wellness visits for dependent children. These are covered without deductible. The table above illustrates the deductibles and the manner in which aggregate family deductibles are calculated.

If more than one person in the family is injured in the same accident**,** *special deductible arrangements* may be made to alleviate the financial impact on your family. Contact the Fund Administrator.

*Important note: the out-of-pocket drug costs of Medicare-eligible retirees are* ***excluded*** *from these deductibles. However,* ***the deductibles apply to all covered non-drug out-of-pocket expenses for Medicare-eligible retirees enrolled in any of the City-approved health plans****. For more information on Superimposed Major Medical coverage of Medicare-eligible retiree drug costs, see section IIA2 on Prescription Drugs on page 3 and 4.*

**How Does The Welfare Fund Calculate Your SMMP Reimbursement?**

After you satisfy the deductibles in the box on page four, the plan reimburses:

- 90% of non-reimbursed covered medical and hospital expenses at "reasonable and customary" allowances
- 80% of non-reimbursed covered pharmaceutical drug expenses for active and non-Medicare retirees
- 90% of non-reimbursed covered outpatient substance abuse care visits
- 90% of non-reimbursed covered outpatient psychiatric care visits

When your out-of-pocket expenses reach $2,500 (that is, your total uncovered expenses, subject to "reasonable and customary" allowances minus your deductible and minus your total reimbursements from all insurance, including SMMP) the plan will then cover 100% of the "reasonable and customary" allowances for non-reimbursed covered medical and hospital expenses in excess of $2,500.

## Important Rules Governing the Superimposed Major Medical Plan:

- **The SMMP plan is not a Basic (Primary) Health Plan. You must follow the rules of your Basic (Primary) Health Plan – otherwise, the OSAWF is not liable for the reimbursement of any expenses.**
- **If you or your eligible dependents are covered under a Health Maintenance Organization (HMO) plan or your Basic (Primary) Health Plan provides a benefit for services only through a network of participating providers, the Superimposed Major Medical plan does not cover services provided by an out-of-network provider.**
- **Furnish a copy of your Basic (Primary) medical plan I.D. card with the first claim submitted each calendar year.**
- **Furnish a copy of settled claims of any/all other group plan insurers. See coordination of benefits.**
- **File your claim within two years of the date of service, or within one year of settlement by other medical plans.**
- **If a person becomes totally disabled, he or she should contact the Fund Administrator for a possible extension of benefits.**

## 3. HOME HEALTH CARE

Room, board and other charges for medical care during confinement in an extended care facility are covered by SMMP if your doctor certifies that **24-hour nursing care** is **medically necessary**. You must follow the rules of your primary health insurer.

Similarly, certain services received in your home are covered by SMMP:

- Part-time nursing care by a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Public Health Nurse or a Licensed Vocational Nurse working under supervision of an RN.

- Physical, occupational, or speech therapy, or use of medical equipment provided on an outpatient basis by a home health agency or a hospital or other care facility (and arranged with a home health agency).

- Part-time home health aide services for the care of the insured person. (Home Health Agency benefits do not include service provided by a member of the insured person's immediate family, nor by a person who normally lives in the insured person's home, nor does it include services which are not needed for the treatment of a sickness or injury. Please talk to the Fund Administrator for specifics.)

## 4. MENTAL HEALTH CARE

### OUTPATIENT PSYCHIATRIC CARE & COUNSELING

Outpatient psychiatric care coverage includes only the professional fees of a Doctor, or a Licensed Clinical Social Worker or Licensed Master Social Worker on a list maintained by the New York State Education Department's Office of the Professions. You can verify that a social worker is either a Licensed Clinical or Master Social Worker at the website **www.op.nysed.gov/opsearches.htm**.

Follow the instructions to search by name or license number. In the drop-down menu, highlight Licensed Clinical or Licensed Master Social Worker, insert the information (name or license number) as instructed and click "search." Be sure to search twice since a Licensed Social Worker could be on either list.

You may also call 1-518-474-3817 and follow the prompts or dial extension 450. It may be helpful to have the provider's license number, especially in a situation where a provider has a very common name.

After satisfying the **SMMP deductible**, non-reimbursed covered charges incurred by an insured person are reimbursed at the rate of **90%.**

Payments for Psychiatric Outpatient Treatment will be counted towards the SMMP Deductible.

### OUTPATIENT SUBSTANCE ABUSE CARE

In addition to visits for the diagnosis and treatment of the patient for **Drug/Substance Abuse treatment** services, the Superimposed Major Medical Plan also covers visits for counseling for certain family members of the person in need of treatment. Benefits will be paid at **90%**. Contact the Fund Administrator for specifics.

### IN-PATIENT MENTAL HEALTH & SUBSTANCE ABUSE CARE

SMMP coverage for Mental Health and Substance Abuse Care in-patient confinement is covered subject to review for medical necessity. You must follow all rules of your primary health plan, including any pre-certification procedures, if required. Failure to obtain a needed pre-certification will result in exclusion from coverage by the OSAWF as well.

## B. AUDIOMETRIC (HEARING AIDS AND EXAMINATIONS)

You are entitled to **a maximum benefit of $1,500** for hearing aids and audiometric examinations **during a 24 month period**. The plan covers up to **90% of the reasonable and customary charges** for one audiometric examination per person in that 24 month period and one hearing aid per ear during the same period. There is no cash deductible for hearing aids. For convenience sake, the Hearing Aid benefit may be claimed on an OSA Superimposed Major Medical form.

# III. DENTAL BENEFITS

**Benefit Year: July 1 - June 30**

The Dental Plan provides for up to $4,000 per covered person per benefit year (the plan limit).

You may use either a **participating** or a **non-participating** dentist, but the benefit differs for each option. You may use a participating provider for one specialty and a non-participating provider for another. The Dental Plan provides a $4,000 lifetime benefit for orthodontic care as a separate benefit, *in addition to* the $4,000 per person Dental Plan annual benefit limit.

A pre-certification is advisable for any extensive treatment, and is required for orthodontia and prosthetics. Pre-certification will help you and your dentist plan both treatment and expenses.

If you think your coverage might end while you are in treatment, contact the fund. Certain procedures may be covered for a limited time even after your coverage ends.

## A. NON-PARTICIPATING PROVIDER

After a **deductible** of **$50** per person (or **$150 per family)**, covered members and their families will be reimbursed for **up to 80% of our schedule** up to **the plan limit**. The deductible is waived for preventive care expenses such as oral exams, cleaning, and x-rays.

There may be more than one method of treating a certain dental condition. In such cases, covered charges will ordinarily be limited to the charge for the **least costly method** that would produce a professionally adequate result.

## B. PARTICIPATING PROVIDER

If you use a Participating Provider, diagnostic and preventive procedures, restorative services, oral surgery and periodontal treatment, and other services are entirely covered up to the plan limit.

**OSAWF** uses the **MetroDent** Group of Participating Dentists. The participating dentists agree to accept a fee schedule which is, usually, lower than their ordinary charges. This should allow you to get more treatment in a given year than you would from a non-participating dentist.

The goal of the Welfare Fund is to arrange it so there is no out-of-pocket cost to you when you choose to use a participating provider.

Please remember that, for complex procedures, pre-certification is recommended, and for orthodontia and prosthetics, it is required.

Before obtaining services, please be sure to check that your provider is still a participating provider in the **MetroDent** plan.

The names of **MetroDent** participating dentists are available from SIDS or by using the union website at **www.osaunion.org**. Simply click on *Member Services*, then on *OSA Welfare Fund Benefits*. Click on the **MetroDent** logo and follow the instructions to search for participating providers and review your individual eligibility.

### Important Rules Governing Dental Benefits:

- **You must make your Claim for Dental Benefits within one year from the Date of Service.**
- **The maximum lifetime benefit for a covered person for any course of orthodontic treatment, including diagnosis, evaluation and pre-care is $4,000 – in *addition* to the annual $4,000 plan limit.**
- **Pre-treatment estimates are required for orthodontic treatment and prosthetic procedures including crowns, laminates, inlays, dentures, dental implants, bridge work (full or partial) and for periodontal surgery.**
- **If you are eligible for benefits under more than one dental plan, the dentist is entitled to collect up to the maximum payment from both plans but not more than his/her usual and customary fee. In such a case, the payment received from the second plan will be applied first towards the Member co-pay, thereby reducing or eliminating the co-pay amount. See coordination of benefits.**

- **New Members: There is a two year waiting period for certain dental work. Call OSAWF for details**.
- **The dental plan will reimburse for two dental implants per plan year, but *only within the $4,000 annual limitation*. There is a maximum of six implants in the course of a lifetime. Reimbursement on dental implants is relatively low given their high cost. It may well be worth exploring other options with your dentist before considering implants. Please note that, while the Fund pays for implants, it does not cover implant-related services such as custom abutments, sinus lifts or grafts, etc.**
- **The Dental Plan does have certain limitations. For example:**

| | |
|---|---|
| **Examination** | **once in 6 months** |
| **Full Mouth Series or Panoramic Xray** | **once in 12 months, to a maximum of $75** |
| **Bitewing Series** | **once in 6 months** |
| **Prophylaxis** | **once in 6 months, not paid same day as scaling** |
| **Fluoride treatment** | **one a year, to age 16** |
| **Pit & Fissure Sealants** | **permanent molars to age 16, lifetime max of two applications** |
| **Therapeutic Pulpotomy** | **to age 16** |
| **Perio scaling and root planing** | **six in 12 months; not paid on the same day as prophylaxis** |
| **Gingival curettage** | **once in quadrant in 12 mos.; not paid same day as prophylaxis** |
| **Replacement of prosthetic appliance** | **once in 5 years** |
| **Denture reline** | **once in 5 years** |
| **Orthodontic treatment** | **$4000 lifetime maximum benefit, in addition to the $4000 annual plan limit** |
| **Palliative treatment** | **paid only if no other service rendered that day** |
| **Periodontal Maintenance Procedure** | **following active therapy, four in a 12 month period** |
| **Implants** | **two implants payable per plan year; a maximum of six implants in a lifetime** |

# IV. OPTICAL BENEFITS

**Benefit Year: March 1 - February 28**

## A. EVERYDAY EYE CARE

Our current Optical administrator is Davis Vision. DavisVision may be contacted at (800) 999-5431 or from the union's website at **www. osaunion.org**. Go to *Member Services,* click on the icon for *Welfare Fund Benefits,* then scroll to the icon for *DavisVision* and click on it. You may also use DavisVision's website at **www.davisvision.com**. DavisVision member service representatives are available Monday through Friday, 8am to 8pm, Eastern time, and Saturday, 9am to 4pm Eastern time. Members who use a TTY (Teletype-writer) because of a hearing or speech impairment may access TTY services by calling 1-800-523-2847.

All members and covered family members are entitled to one vision examination and one pair of lenses or contact lenses once per benefit year either from an In-Network or an Out-of-Network Provider. You are covered for a pair of frames once per benefit year when using an In-Network provider and once every two benefit years when using an Out-of-Network Provider.

At the beginning of every benefit year, each covered individual in your family may decide to use **either** an In-Network or Out-of-Network Provider, but not both. A benefit brochure is available from DavisVision or the union on request.

### 1. IN-NETWORK PROVIDER BENEFITS

If you choose to use an In-Network Provider there is **no charge to you for the following services**:

1) An eye examination, including dilation as professionally indicated.
2) Tonometry (glaucoma testing)
3) A pair of lenses:

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range;
- Glass grey #3 prescription lenses;
- Oversize lenses;
- Post-cataract lenses;
- Fashion, sun or gradient tinted plastic lenses;
- Photogrey Extra® (photosensitive) glass lenses (lenses that change from light to dark in varying mounts epending on exposure to ultraviolet light.);
- Blended invisible bifocals (a lens with two different segments – one for distance vision and one for near vision with no visible line);
- Polycarbonate lenses (a high index, impact-resistant plastic lens);
- Ultraviolet (UV) coating (a lens coating which blocks ultraviolet light);
- Standard and premium types of progressive addition lenses (A no-line lens with a gradual blend of pre-scriptions, from that needed for distance viewing at the top to that needed for reading at the bottom. Can be worn instead of bi- and tri-focals and come in glass, plastic, high index and polycarbonate materials, as well as photochromic glass, plastic and high index. Progressive addition multifocals can be worn by most people, but conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive addition lenses);
- Scratch-resistant coating (a hard clear coating on plastic lenses to increase scratch resistance);
- Intermediate vision lenses (covers two distinct powers – a near vision zone and an intermediate vision zone optimized for distances of 2-4 feet)
- Standard and premium brands of ARC (anti-reflective coating – a clear coating that limits glare on the internal and external surfaces of the lens);
- Polarized lenses (laminated lenses with a layer of polarizing material that filters light from a particular direction, reducing glare from reflective surfaces);
- Plastic photosensitive lenses (lenses that darken when exposed to ultraviolet light either through a color-changing coating or a photochromic substance mixed throughout the lens);
- High-index (thinner and lighter) lenses. (For patients requiring strong prescriptions, provides the same amount of visual correction with less material – glass or plastic – than traditional lenses.)

4) New and existing contact lens wearers will receive a supply (two multi-packs) of lenses, along with all necessary visits for proper fitting and recommended follow-up care.
5) A pair of frames selected from **the Premier selection of frames from the exclusive "Tower Collection"** in most network provider offices.

6) Contact lenses — no copayment is required for standard, soft, daily-wear, disposable or planned replacement contact lenses in lieu of eyeglasses. The patients' out-of-pocket expense (if any) will vary depending on the lenses prescribed. Your provider will give you specific copayment information for the type of lenses you require. Please note: once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. *Routine eye examinations may not include professional services for contact lens evaluations*. Any applicable fees are the patient's responsibility.

If you choose to use an In-Network Provider there will be **an extra charge for the following:**

1) Non-Plan Lenses and Frames: **If you choose a frame that is not part of the exclusive "Tower Collection," a $14.00 credit will be applied toward the cost of a network provider's own frame.** You will be responsible for the remainder without reimbursement from OSAWF. Lenses and coatings other than those outlined in the section above (if any) will also incur extra cost.
2) Non-Plan Contact Lenses: **If you choose contact lenses other than those within the plan, a $94.00 credit will be applied toward the cost of a network provider's own supply of contact lenses.**

### USING DAVIS VISION IN-NETWORK PROVIDERS

- You may obtain assistance in selecting a provider from DavisVision by phone at (800) 999-5431. You may also search for Participating Providers on the DavisVision website by zip code and by distance in miles from that core zip code. Go to the *Member Services* section of the union's website **www.osaunion.org** and click on the *Welfare Fund Benefits* icon, then click on the *DavisVision icon* on that page. On the DavisVision site provide the information requested to identify yourself, then click on "Find A Doctor."
- Select a provider and schedule an appointment. Identify yourself as part of the DavisVision plan and an Organization of Staff Analysts Welfare Fund member or covered dependent. Provide the office with the member's Social Security/ID number and the date of birth of any covered children needing services. The provider's office will verify your eligibility for services. No claim forms or ID cards are required. If you are also getting VDT glasses, give the provider the form.

## 2. OUT-OF-NETWORK PROVIDER BENEFITS

You may receive services from an out-of-network provider. If you choose an out-of-network provider, you must pay the provider directly for all charges and submit a claim for reimbursement to: DavisVision, Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110.

**Note: You may submit a claim for reimbursement for an eye exam and lenses or contact lenses from an out-of-network provider only once per plan year. Frames from an out-of-network provider are covered only once in every two plan years.**

Forms can be obtained from the union's website at www.osaunion.org. Go to *Member Services* and click on the icon for *OSA Welfare Fund Forms.* You will find a link for downloading the non-network vision provider form. It is in PDF format, so you must have Adobe Reader on your hard drive. If you don't, you can download the program from www.adobe.com.

You may also download forms from the DavisVision website at www.davisvision.com or call Davis Vision at (800) 999-5431 or the OSAWF at (212) 686-1229.

- You will receive reimbursement of **100% of your actual expense** up to a **$150 maximum** benefit.
- **Frames will be covered only once in every two (2) benefit years.**

## B. LASER VISION CORRECTION SERVICES

DavisVision provides members and eligible dependents the opportunity to receive Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons (some providers have flat fees equivalent to these discounts). For info, visit www.davisvision.com or call (800) 999-5431.

## C. VDT OPTICAL BENEFIT

In addition to your regular optical coverage, if you use a computer or **V**ideo **D**isplay **T**erminal **at work,** you can get a voucher which will entitle you to an eye exam and a pair of VDT glasses **every two (2) years**. Please note that members employed by the Department of Education are not eligible for this benefit.

VDT eyeglasses are prescribed specifically for the unique distance and height of the computer. Computer screens are typically farther away than traditional reading material, requiring a different lens power and a little higher line of sight. This benefit *requires* your employer to certify that you use a computer in the regular course of your work.

**All members must use the voucher at the same time they have their regular exam for glasses.** Request the voucher **from DavisVision at (800) 999-5431.** Remember that the VDT voucher is only good for 45 days from the date of issue on the voucher. Please call the OSAWF at (212) 686-1229 with any questions about the VDT Program. **VDT glasses must be obtained from an in-network provider.**

## D. REPLACEMENT CONTACT LENSES BY MAIL

DavisVision offers free membership in and access to a mail order replacement contact lens service, Lens 123, which provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1 (800) LENS-123 (1-800-536-7123) or visit www.lensl23.com. Call and identify yourself as a DavisVision program participant. You will be asked to fax or send your current lens prescription. Most replacement lenses or solutions are shipped the same day.

## E. WARRANTIES ON MATERIALS PROVIDED BY DAVISVISION

DavisVision warranties plan lenses/frames as follows:

- **Scratch Resistant Coatings** are warrantied for one (1) year from the original date of dispensing. Scratched lenses that originally included a scratch resistant coating will be replaced with new lenses of the same material, style & prescription at no charge.
- **Anti-Reflective Coatings (ARC)** are warrantied for a period of one (1) year from the original date of dispensing. Lenses that have had anti-reflective coating applied which is peeling or cracking will be replaced with new coated or uncoated lenses of the same material, style and prescription at no charge. The ARC warranty does not cover scratches.
- **Frame style, lens style and/or lens material** are warrantied for thirty (30) calendar days from the original date of dispensing. Any pair of eyewear may be returned to your provider for changes to the frames and/or lenses selected.
- **Change of prescription**. Your optical provider may make any prescription changes necessary to ensure the best possible vision for either ninety (90) calendar days for plan eyewear or thirty (30) calendar days for plan contact lenses from the original date of dispensing.
- **Non-adaptation to progressive addition (no-line bifocal) lenses.** Progressive addition lenses, also known as no-line bifocals, allow wearers to see near, far and in-between without visible lines. While most patients successfully adapt to no-line bifocals, a very small segment of the population may need to return to conventional lenses. For sixty (60) calendar days from the original date of dispensing, progressive lenses may be returned for replacement with conventional single vision, bifocal, or trifocal lenses. Any co-payments associated with selection of the original progressive addition lenses will not be returned.
- **Breakage warranty for plan supplied frames and/or lenses.** All materials provided by DavisVision labs are unconditionally guaranteed for one (1) year from the original date of dispensing. Replacement materials identical to these originally ordered will be supplied at no cost if your materials should break within the warranty period.
- **Allergic reaction to plan supplied frames**. A very small percentage of people may experience an allergic reaction to certain metal alloys in some eyeglass frames. Should this occur within the first ninety (90) days from the original date of dispensing, DavisVision will provide a new complete pair of eyeglasses in an alternate frame at no charge.

**Please note:** *Warranty periods are based on the date associated with the original pair of eyewear. Replacement materials will be covered for the remainder of the* ***original warranty period****.* As it is not possible for DavisVision to know the exact date of dispensing, once materials are shipped to your provider, it is assumed that dispensing occurs within ten (10) days of the shipment date. If you have questions about warranties, please contact DavisVision at (800) 999-5431.

### Important Rules Governing Optical Benefits:

- **If you use an Out-Of-Network Provider, you must make a claim for optical benefit within <u>one year</u> from the date of service. In addition, you may submit a claim for reimbursement for services from an out-of-network provider only once per plan year.**

- **In order to use your VDT benefit, you <u>must</u> do it at the same time you get a regular pair of glasses or an eye examination from an In-Network Provider.**

- **Payment is *not included* in your optical benefit for:**

  - Medical treatment of eye disease or injury.
  - Vision therapy.
  - Special lens designs or coatings, other than those previously described.
  - Replacement of lost eyewear.
  - Non-prescription (piano) lenses.
  - Services not performed by licensed personnel.
  - Contact lenses and dress eyewear in the same benefit cycle.
  - Two pairs of eyeglasses in lieu of a bifocal
  - Frames from an Out-of-Network provider more frequently than once every two benefit years.

## V. LONG TERM DISABILITY INSURANCE

The purpose of Long Term Disability Insurance (LTD) is to provide some protection against the income lost as a result of illness or injury. Members are particularly vulnerable in the period when leave credits have been exhausted and Social Security Disability benefits may not yet be available.

If you work 30 hours or more a week, you are eligible for long term disability payments after a benefit waiting period of 6 months from your **last day of full time work.** For claims filed May 1, 2010 and after, the **monthly benefit** is $1,000 per month (subject to a 50% of income limit.). For claims filed prior to May 1, 2010, please consult the 2009 Welfare Fund benefit book or call Michelle Rivas of the Fund for information.

Although LTD payments are reduced if you are in full pay status, you are still better off in full pay status, since your salary plus your reduced benefit will still be greater than the normal LTD benefit alone.

Since it is clear that you will be better off in full pay status, you must exhaust all your leave credits, and should ask for an advance against sick leave if your agency permits. It is **very** important that you contact the **OSAWF** on your last day of work. The **OSAWF** will assist you with the information you need to protect yourself and your family with medical coverage through **SLOAC and/or FMLA.**

If you are receiving LTD, you are entitled, by agreement of the OSAWF trustees, to be reimbursed for your COBRA payments for OSAWF benefits and basic health insurance for up to 29 months. A copy of your bill for COBRA from your basic health plan and a copy of your check/payment to your basic health plan must be submitted to the OSAWF.

When you are approved for LTD, the OSAWF will reimburse you for your basic health premiums back to the date when COBRA payments first began, which should be when SLOAC (a four month leave grant) ended, or when you were no longer on the OSAWF, whichever was later. The 29 month COBRA coverage period will be calculated from that date.

You will be contacted throughout the receipt of LTD to determine if an application for retirement has been made and/or whether you are eligible. When you return to work or retire because of age or disability, your basic health plan will reimburse you for COBRA payments made by you for basic health back to the date of application for retirement or the date you return to work. You must, in turn, reimburse the OSAWF for these payments.

The length of the Benefit Period for Long Term Disability depends on your age at disability, as follows:

| **Age (yrs)** | **61 or less** | **62** | **63** | **64** | **65** | **66** | **67** | **68** | **69+** |
|---|---|---|---|---|---|---|---|---|---|
| Maximum Benefit Period (Months) | until age 65 | 42 mos. | 36 mos. | 30 mos. | 24 mos. | 21 mos. | 18 mos. | 15 mos. | 12 mos. |

# VI. LIFE INSURANCE

While you are a member of the **OSAWF**, you are covered under a group life insurance plan which has accidental dismemberment provisions.

**Conversion Rights**: When a person is no longer eligible for **OSAWF** coverage, the policy may be converted within 31 days, which allows you to continue coverage without interruption and at your own cost. The Fund Administrator will provide the details.

## A. ACCIDENTAL DEATH OR DISMEMBERMENT

The **Table of Losses** for Accidental Death or Dismemberment is available from the Fund Administrator**.**

## B. MEMBER DEATH BENEFIT

The table below summarizes the amount which will be paid in the event of the death of a member.

| **Work Status** | **Age** | **Benefit Amount** |
|---|---|---|
| **Active** Employees | under age 65 | $ 50,000 |
| | age 65-69 | $ 32,500 |
| | age 70 | $ 25,000 |
| **Retired** Employees | any age | $ 5,000 |

# VII. OPTIONAL GROUP INSURANCE

## A. OPTIONAL GROUP LIFE INSURANCE

You are eligible to **purchase** Group Life Insurance, through the **OSAWF**, for yourself, your spouse, or your children. Contact the Fund Administrator for details.

## B. OPTIONAL SHORT TERM DISABILITY INSURANCE

Active members are eligible to **purchase** Short Term Disability Insurance through Winston Financial Services. This disability income plan supplements the existing group long term disability coverage provided by the OSA Welfare Fund. The plan provides additional income protection in the event of disability from sickness or accident. You must be actively at work to enroll (retirees are not eligible). You can download a brochure with details of the coverage on our website at www.osaunion.org. Click on Member Services and then on Additional Benefits. To learn more about your options, call Winston's Customer Service Center at 1-800-347-6071. A representative can answer your questions and will help you schedule an appointment with an enrollment counselor. Educational meetings and enrollment sessions can be held at work locations and you can request a site visit when speaking with the call center representative.

# VIII. SURVIVOR BENEFITS

When a member dies, the **OSAWF** will continue coverage of basic health insurance, including any Optional Rider, for the surviving spouse/domestic partner and any eligible dependent children, by reimbursing the survivor for their COBRA payments for three years. The Fund will also provide **SMMP, Dental,** and **Optical** benefits for the same period. If the *survivor* is a City employee or retiree him/herself, basic health insurance will continue to be paid by the City and OSAWF will only provide **SMMP, Dental** and **Optical** benefits. To assure a smooth transition, a survivor should contact the **OSAWF** Fund Administrator upon the death of a a member.

# IX. OSAWF COBRA CONTINUATION

Members, their spouses/domestic partners and dependents may extend coverage of certain **OSAWF** benefits through **COBRA.** Certain individual benefits may be selected, and conditions of coverage apply. If your **OSAWF** benefits end or are about to end (because you leave full-time payroll), be sure to contact the Fund administrator promptly for details. The table below delineates the time limits for COBRA continuation.

| | **Reason for Loss of Benefit** | **Maximum COBRA Continuation** |
|---|---|---|
| Members | reduction in hours of work<br>termination<br>deferred retirement<br>disabled (under certain conditions) | 36 months<br>36 months<br>36 months<br>36 months |
| Spouses/Partners | death of member<br>termination of member<br>reduction in hours of work<br>divorce/termination of partnership<br>deferred retirement of member<br>disability of member(conditions apply)<br>active military duty of a reservist | 36 months<br>36 months<br>36 months<br>36 months<br>36 montns<br>36 months<br>during active service |
| Dependent Children | death of member parent<br>termination of member parent's<br>member parent-reduction of hours<br>dependent no longer qualified<br>active military duty of a reservist | 36 months<br>36 months<br>36 months<br>36 months<br>during active service |

If you become eligible for Long-Term Disability, and have incurred COBRA costs because all of your leave credits have been exhausted, **OSAWF** may reimburse you for your COBRA payments. For more information, see the section on Long Term Disability on page 12 of this booklet.

# X. PENSION COUNSELING

OSAWF maintains a cadre of trained pension counselors. There are a wide variety of pension plans and options for New York City employees. This can be very confusing. At least once a year, through our "pre-retirement seminar," and more often if a retirement incentive is being offered, the OSA Welfare Fund offers group lectures to discuss general planning and to review changes that you will need to anticipate as you approach and enter retirement.

Individual counseling sessions are available year round, to cover your individual situation, so that you understand your income and health benefits in retirement.

If you are interested, call the union office at (212) 686-1229. Sessions are usually held after work, and last an hour or more. A member need not be ready to retire to ask for a session--younger members, even those who have not yet enrolled in a pension plan, are welcome. Our counselors want you to understand the plans. There is no charge to members for this service.

# XI. MISCELLANEOUS NOTES

## YOUR DOMESTIC PARTNER

Your domestic partner is covered **if eligible** for coverage as a Domestic Partner **under the City of New York's Health Benefits Program.** An eligible Domestic Partner is covered for **OSAWF Superimposed Major Medical, Dental** and **Optical Benefits.** At the current time, the benefits paid for a domestic partner are taxable. You will receive a statement of taxable income from the City.

## YOUNG ADULT DEPENDENT COVERAGE

Congress and the NY State legislature each passed laws in recent years that allow certain young adult dependents of employed or retired parents to continue their basic health care coverage until they are 26 (under the federal law) or 30 (under the New York State law). The OSA Welfare Fund has extended its coverage to young adult dependents of active or retired members following the same guidelines.

Information describing the coverage available to OSA members/retirees and their young adult dependents is posted in the *Member Services* section of our website under *Welfare Fund Forms*. It describes eligibility under each law.

- The federal law covers all dependents, regardless of marital status, until their 26th birthday – so long as they are not covered by or eligible for other health insurance through their employer. Any young adult dependent, married or unmarried, between the ages of 19 and 26 (including those previously covered while in school through age 23) are covered by the parent's OSA Welfare Fund family coverage at no additional cost, provided the member completes and submits the "Age 26 Young Adult Dependent Coverage Enrollment Form" posted in the *Member Services* section of our website under *Welfare Fund Forms*. This form must be completed and submitted by January 1st every benefit year for any young adult dependent under 26 whom you wish to cover – until that dependent turns 26 or you no longer wish to cover that dependent. You are no longer required to provide proof of school enrollment for a young adult dependent between the ages of 19 and 23.

- The NY State law covers unmarried dependents until their 30th birthday. Unmarried young adult dependents between the ages of 26 and 30 can purchase individual OSA Welfare Fund coverage for superimposed major medical and/or dental and vision services. To purchase this individual young adult dependent coverage from the OSA Welfare Fund, you must complete and submit the "Age 29 Young Adult Dependent Coverage Enrollment Form" posted in the *Member Services* section of our website under *Welfare Fund Forms*. Consult the information on the form about enrollment and payment.

When the parent of a young adult dependent leaves city service and is no longer eligible for basic health coverage from the City and OSA Welfare Fund coverage from the union, the parent can purchase basic health and Welfare Fund coverage for up to 36 months through COBRA .

In that case, a young adult dependent who was covered at the time of the parent's break in service also remains eligible for an additional 36 months of OSA Welfare Fund coverage through COBRA, so long as the parent purchases COBRA.

However, in all circumstances OSA Welfare Fund coverage ends when the young adult dependent turns 30.

## NOTICE OF GRANDFATHERED PLAN

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator – Sheila Gorsky, OSA Welfare Fund, 220 East 23rd Street, Suite 707, New York NY 10010.

## SLOAC & FMLA

**The Family and Medical Leave Act (FMLA) of 1993** entitles you to up to 12 weeks of paid or unpaid leave to deal with your own serious medical problem or that of a family member.

When you are out of work during an *unpaid leave* resulting from *your own* serious disability or illness, you are also entitled to up to 18 weeks of **Special Leave of Absence Coverage (SLOAC),** at your agency's discretion, to continue your health insurance coverage.

During the period when you are covered for FMLA and/or SLOAC, your basic health coverage will continue, as will your **OSAWF** benefits (SMMP, Hearing, Dental, Optical, and Basic Life Insurance). Contact the Fund as soon as you believe you will be approved for either FMLA or SLOAC.

**Please remember that drug coverage is not considered a part of your basic health coverage. You pay for it through deductions from your paycheck, so if your paycheck stops, so does your drug coverage. Therefore, if you are now receiving SLOAC or FMLA and wish to continue your drug rider coverage, you must contact your basic health insurance plan to make your drug rider payments directly to them. You should also contact the provider for any other services deducted from your paycheck (i.e. optional life insurance, short term disability insurance, etc.) to make arrangements for direct payment to the provider for those services.**

## COORDINATION OF BENEFITS

If you or your dependent is also covered by another insurance plan, insurance payments will be coordinated. The total benefits paid by all plans together will not exceed the **actual total** allowable expenses. If the expense is covered by both plans, however, your eventual share of costs will be lowered unless the **entire** amount is covered.

## APPEAL OF CLAIM DENIAL PROCEDURE

Claims for Superimposed Major Medical, Optical and Dental Benefits must be made within the time periods set forth at the bottom of the applicable descriptions of benefits above. Appeals of claim denials must be made in writing to the Trustees within 60 days from the receipt of the claim denial. Appeals must be mailed to: Trustees, OSA Welfare Fund, 220 East 23rd Street, Suite 707, NY, NY 10010.

## MAKE SURE YOU CONTACT THE FUND:

- **If there is a birth or adoption.**
- **If there is a marriage, divorce or change in the family situation.**
- **If there is a serious accident involving more than one member of your family.**
- **If our member or one of his/her dependents dies.**
- **If the member becomes permanently disabled.**
- **If you change from full-time to part-time status, part-time to full-time status, if hours are reduced to less than 17½ hours or increased to more than 17½ hours.**
- **If you *think* you are eligible for long term disability benefits.**
- **If/when you become eligible for Medicare.**
- **If you want to purchase Group Universal Life Insurance through OSA.**
- **If you want pension counseling.**
- **If there is a complicated problem which you would like to discuss or clarify.**
- **If you need advice or help in using the benefits.**