Montefiore | Nyack

Welcome to Montefiore Nyack Hospital

NYSNA RN Benefits Packet

Montefiore | Nyack

Highlights of Benefits Program
Registered Nurse

This overview provides a snapshot of the benefits program being offered to Registered Nurses working for Montefiore Nyack Hospital. Your medical, dental, vision, life insurance, pension, and disability benefits will be provided under the NYSNA Benefit Fund. Refer to the plan booklets or summary plan descriptions for a more detailed explanation of the benefits available.

Eligibility	Regular full and part-time employees who work at least 37.5 hours in a bi-weekly period are eligible to participate in the group medical, dental, vision, disability and life insurance plans.
Effective Date of Insurance Coverage	If you enroll in the insurance plans on a timely basis, your coverage will take effect on the 91st day of employment.
Tax Sheltered Annuity 403(B)	You can sign up immediately for this program through Transamerica 1-800-755-5801 or www.trsretire.com. There is no waiting period.
Contributions	You share in the cost of coverage for your medical, dental, vision, life, and disability plan. Refer to the Rate Sheet for the amount of contributions required for coverage. Your contributions are made with pre-tax dollars.

AN OVERVIEW OF THE PLANS

Enrolling in the NYSNA Benefit Fund Insurance Policies	Coverage with the NYSNA Benefit Fund is all inclusive, meaning if you enroll, you are enrolling in medical, dental, vision, life, and disability policies. If you waive coverage, you decline all coverage. Full time employees who waive coverage and provide us with proof of other medical coverage will be given up to $2,400 per year as a cash back credit. **This benefit must be renewed annually.**

NYSNA Medical Plan - Anthem BCBS	
- In- Network Care	There are no deductible or co-insurance amounts if you use in-network providers. All you are required to pay is a $10 co-pay for office visits, $25 co-pay for speciality office visits, and a $75 co-pay for ER visits. If Montefiore Nyack Hospital is used for medical care, any co-pay amount is forgiven.
- Out-of-Network Care	Individuals must first meet a $250 deductible and reasonable and customary expenses are covered at 70%. The maximum family deductible is $500 per calendar year.
-Prescription Drugs	You must use an in-network pharmacy. The co-pay is $0 for Generic Formulary Drugs, $10 for Brand Name Formulary Drugs and $20 for non-formulary drugs.

NYSNA Dental Plan - Aetna	This is a PPO plan that allows you to receive treatment from dentists participating in Aetna's network or from non-participating dentists. The plan covers Preventive, Basic and Major services. There is a $0 deductible in-network and a $50 deductible for single coverage and a $150 deductible for family out-of-network services.
- Preventitive Care	Paid at 100% In-Network - 80% Out-of-Network
- Basic Care	Paid at 80%
- Major Care	Paid at 50%
- Maximum Benefit	$1,200 Max for both In & Out-of-Network

NYSNA Vision Plan - Davis	
- Examinations	In-Network $10 co-pay per visit every 2 years (every year for children up to age 18)
- Lenses, Frames, Contacts	$30 co-pay, $150 credit toward non-plan frames, or $25 co-pay for disposable/planned replacement lenses

Group Life & A.D. & D.	Paid at a minimum of $20,000 and a maximum of $50,000 computed by taking 150% of the current base compensation to the maximum allowable amount. Benefit reduced 35% at age 65, and 50% at age 70. AD&D paid at 100% or 50% of maximum benefit according to specific loss
NYSNA Disability Insurance	Paid at two-thirds of regular, weekly compenation, up to $215 per week for a maximum of 26 weeks after being out of work for at least 1 week with a qualifying medical condition
Supplemental Short Term Disability	This is a payroll deduction program available to full and part time employees through Unum. If you elect to participate, the plan will pay a benefit of 60% of your salary to a maximum of $1,000 per week in addition to the statutory benefit payable from New York State if you qualify for disability benefits. Information on this program is available, upon request, from HR.
Voluntary Long Term Disability	This is a payroll deduction program available to full and part time employees through Unum. Voluntary Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 180 days. The plan provides you with income protection to replace up to 50% of your earnings, to a maximum monthly benefit of $5,000.
NYSNA Pension Plan **518-869-9501**	The New York State Nurses Association Pension Plan is a defined benefit pension plan that was established Jan. 1, 1972, through collective bargaining agreements between the New York State Nurses Association (NYSNA) and contributing employers, to provide pension benefits for vested Plan participants when they retire.
Tuition Reimbursement	The Hospital encourages employees to continue to develop their skills. Through the Tuition Reimbursement program, the Hospital will pay up to $8,000 a year for approved courses ($4,000 if you are part-time).

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NYSNA BENEFITS FUND DEDUCTION AUTHORIZATION

1. ELECTION TO PARTICIPATE IN NYSNA BENEFITS FUND

☐ I ***DO*** wish to participate in the Health Insurance Plan through **NYSNA Benefits Fund**

- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + Two Dependents
- ☐ Employee + Three or More Dependents

2. ELECTION TO WAIVE COVERAGE

☐ I ***DO NOT*** wish to participate in the Health Insurance Plan through **NYSNA Benefits Fund**

If you waive medical coverage and are currently a full time employee you may be entitled to receive cash back payments of $200 per month
In order to qualify for cash back payments, you must be full time and provide proof of insurance in the form of a letter from the Administrator of the group health plan or the covered employee's Personnel/Human Resources Dept. All individuals being opted-out must submit the letter with this application. Insurance ID cards are NOT acceptable forms of proof of insurance.

3. ELECTIONS ARE NOT REVOCABLE

The medical and dental plan elections that you make may not be revoked until the next Open Enrollment Period of the plan unless you have a "qualifying event"

- Marriage
- Divorce*
- Birth or placement of child for adoption
- Death of spouse or child
- Legal Separation
- Spouse loses or gains employment
- Unpaid leave of absence
- Transfer to an ineligible employment classification
- Status change**

*In the event of Divorce, employees must notify Human Resources within 60 days to protect Cobra rights for the spouse.
**Status changes generally mean any move between Full Time, Part Time and Per Diem status

4. AUTHORIZATION

This will authorize Nyack Hospital to process the elections that I have made above. I understand that deductions from my salary for coverage will be made on a pre-tax-basis. The rate deducted depends on employment status.

SIGNATURE _____ **DATE** _____

***NAME (PLEASE PRINT)** _____ ***TELEPHONE NUMBER** _____

ALL FORMS MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES FOR PROCESSING PRIOR TO THE EFFECTIVE START DATE OF YOUR BENEFITS

To Be Completed By Human Resources:	
Date of Hire:	Effective Date of Benefits:
Employment Status: PART TIME FULL TIME	☐ NYSNA Notified ☐ Opt Out Approval ☐ Deduction/Cash Back Entered

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PROOF OF DEPENDENT ELIGIBILITY:

TO ADD SPOUSE:

- Provide a copy of Marriage Certificate.

-AND-

- Current Joint Bank Account.

- OR-

- A Utility Statement with both names

TO ADD CHILDREN:

- Provide a copy of each Birth Certificate to show your name as the parent.

-OR-

- Adoption/Legal Guardianship Document.

Important: Social Security Numbers **MUST** be listed on your enrollment forms for **ALL** eligible dependents.

****

FOR HR USE ONLY - Check ✓ Documents Received:

☐ Marriage Certificate
☐ Joint Bank Account
☐ Utility Statement
☐ Birth Certificate(s) ☐ Employee ☐ Children
☐ Adoption/Guardianship Papers

_____

Signature of HR representative receiving document(s).

_____

Date Received

New York State Nurses Association

NYSNA Benefits Fund

PO Box 12430
Albany, NY 12212-2430
(877) RN BENEFITS
www.rnbenefits.org

Social Security Number _____ **Code** _____
(To be filled out by Fund office)

Benefits Fund Enrollment Form

Please print clearly

Last Name _____ First Name _____ Middle Initial ____

Street Address _____ Apt. _____ Birth Date ____/____/____

City _____ State _____ ZIP code _____-_____

Home Phone (___) _____ Cell Phone (___) _____ E-mail _____ ☐ Male ☐ Female

Employer _____ Employment Date ____/____/_____

Position Title _____ Work Status ☐ Full time ☐ Part time ☐ Per diem

Dependents (Spouse, children, stepchildren, ward) ***Marriage and birth certificates are required for coverage.***

Spouse Last Name _____ First Name _____ Birth Date ____/____/____

Spouse's Health Insurance Company _____ Company's Phone Number (___) _____

Spouse's Insurance ID Number _____ Spouse's Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Child Last Name _____ First Name _____ Relationship _____

Birth Date ____/____/____ Social Security Number _____

Life Insurance Beneficiary

If you would like to name more than two beneficiaries for your life insurance, please send the Fund office a notarized letter with all beneficiary names, addresses, Social Security numbers, and relationships listed. If more than one person is named beneficiary, the death benefit will be paid in equal shares to the designated beneficiaries who survive the participant, unless otherwise indicated. If no beneficiary survives, payment will be made in accordance with the terms of the policy.

First Beneficiary Full Name _____

Address _____ City _____ State _____ ZIP _____

Beneficiary Social Security Number _____ Relationship _____

Second Beneficiary Full Name _____

Address _____ City _____ State _____ ZIP _____

Beneficiary Social Security Number _____ Relationship _____

Important Notice

This form must be completed, signed, and received at the Fund office for your Benefits Fund coverage to start. Any person who knowingly and with intent to defraud any insurance company (or other person) files an application for insurance or statement of claim containing any materially false (or conceals for the purpose of misleading) information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and also is subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, pharmacy, or other organization or person having any records of information concerning the health and treatment of me and my dependents to furnish such records to the NYSNA Benefits Fund or its authorized representative, insurance company, or third party administrator.

Signature of Participant _____ Date _____

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

Opt-In Application

Name _____ **Social Security Number** _____

Address _____ **City** _____ **State** ____ **ZIP code** _____

Date of Birth _____ **Date of Hire** _____ **Employer** _____

A participant who has opted out of the Benefits Fund group health coverage can only return to coverage under the Fund:

a. During the November 1 to December 31 open enrollment period (with coverage effective January 1), **or**
b. With notification within 60 days of any of the following life events*:
   1. Death of the covered individual (death certificate and COBRA notification or letter from the covered individual's employer must be provided)
   2. 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)
   3. 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)
   4. Covered individual's employer discontinues group health insurance coverage (a letter or notification from the covered individual's employer must be provided).

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

If you leave employment at the facility where you have opted out of the Benefits Fund group health coverage, and either return to that facility or become employed at another facility that is covered by the Benefits Fund, you will be given another opportunity to be covered or to opt out of the Benefits Fund group health coverage.

Indicate the life event that has taken place:

_____ 1. Death
_____ 2. Termination of employment
_____ 3. Divorce or legal separation
_____ 4. Discontinuance of group health coverage

NOTES: Participants may opt in to Benefits Fund coverage following one of the qualifying life events listed above with required proof of lost coverage. Coverage begins as of the date of the qualifying life event if proper notification is received within 60 days of the life event. If notification is received after 60 days of the qualifying event, the participant must wait until the open enrollment period between November 1 and December 31 to opt in to Benefits Fund coverage with an effective date of January 1.

Indicate the proof of loss of coverage submitted with this application to return to group health coverage in the Benefits Fund:

_____ 1. Death certificate
_____ 2. COBRA notification
_____ 3. Divorce or legal separation decree
_____ 4. Group health discontinuance letter

_____
Signature Date

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

09/2011

Please return this application to your employer

New York State Nurses Association

N Y S N A Benefits Fund
PO Box 12430
Albany, NY, 12212-2430
PHONE (877) RN BENEFITS
FAX (518) 869-9529
www.rnbenefits.org

Opt-Out Application

Name _____ **Social Security Number** _____

Address _____ **City** _____ **State** ____ **ZIP code** _____

Date of Birth _____ **Date of Hire** _____ **Employer** _____

1. Are you opting out of coverage for ____ yourself and all your dependents and/or spouse

   ____ your dependents and spouse only

2. Name and address of person whose benefits will cover you and/or your dependents: _____

   _____

3. Name, address, and telephone number of employer of person in No. 2: _____

   _____

4. Please list the names of the dependents being opted out of coverage _____

   _____

5. Check the coverages provided by your spouse's plan: ____ hospitalization ____ medical ____ dental ____ prescription drug ____ optical

Proof of insurance (in the form of a letter from the Administrator of the group health plan or the covered employee's Personnel/Human Resources Department) for all individuals being opted-out must be submitted with this application. Insurance identification cards ARE NOT acceptable forms of proof of insurance.

A participant who has opted out of the Benefits Fund group health coverage can only return to coverage under the Fund:

a. During the November 1 to December 31 open enrollment period (with coverage effective January 1), **or**
b. With notification within 60 days of any of the following qualifying life events:

   1. Death of the covered individual (death certificate and COBRA notification or letter from the covered individual's employer must be provided)
   2. 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)
   3. 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)
   4. Covered individual's employer discontinues group health insurance coverage (a letter or notification from the covered individual's employer must be provided)

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

If you leave employment at the facility where you have opted out of the Benefits Fund group health coverage, and either return to that facility or become employed at another facility that is covered by the Benefits Fund's group health coverage, you will be given another opportunity to be covered or to opt out of the Benefits Fund group health coverage.

I acknowledge that I have read the information on this form, and understand that if I opt out of the Benefits Fund group health coverage, I will NOT receive coverage for hospitalization, medical, vision, dental, or prescription drugs from the Fund. I further understand that the opt-out will take effect either January 1 or the date I would otherwise be eligible for coverage.

_____
Employee Signature Date

Approved by Hospital:

_____
Signature Date

Approved by Fund office:

_____
Signature Date

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

Please return this application to your employer

10/2012

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MONTEFIORE NYACK HOSPITAL NYSNA EMPLOYEES

2024 NYSNA BENEFITS FUND COVERAGE RATES

FULL TIME REGISTERED NURSES

Type of Coverage	Monthly Premium
Employee Only	$ 25.00
Employee +1 Dependant	$ 50.00
Employee + 2 Dependants	$ 75.00
Employee + 3 or more Dependants	$ 100.00

PART TIME REGISTERED NURSES

Length of Employment	Monthly Premium
Less Than 12 Months of Employment	$ 1,224.34
Greater Than 12 Months of Employment	$ 734.60

Part Time rates are fixed regardless of number of dependants

Montefiore | Nyack

Highland Medical

Co-Payment Waiver Notice

As an employee currently covered under the **Montefiore Nyack Hospital** Medical Plan, the **Highland Medical** Medical Plan or the **NYSNA** Benefit Fund, an important benefit to you and your enrolled dependents is the waiver of any co-payments for services rendered at the hospital or at any of our Highland Medical locations listed below. This important advantage provides you with the opportunity to see a trusted network of leading physicians in the surrounding area who provide high-quality, patient centered care with no out of pocket cost to you. As an example, currently a co-pay for an in-network hospital visit can cost from $35 to $100, and an in-network physician co-pay can cost from $10 to $40 per visit. These costs are now waived under the new plan. By taking advantage of these benefits, you can greatly reduce your out of pocket personal costs for you and your dependents as well as obtain access to highly qualified medical practitioners.

Orangetown Family Practice 97 Route 303 Tappan, NY 10983 **845-359-5005**	**Highland Surgical Associates** 1 Crosfield Avenue, Suite 105 West Nyack, NY 10994 **845-535-3362**	**Dr. Kenneth B. Svensson Family Practice** 46 North Broadway Nyack, NY 10960 **845-353-0202**
Clarkstown Medical Associates 350 South Main Street New City, NY 10956 **845-352-5900**	**Hematology Oncology Associates of Rockland** 160 N. Midland Avenue, 1st. Fl. Nyack, NY 10960 **845-480-7440**	**Pearl River Medical Associates** 275 N. Middletown Road Suite 1F Pearl River, NY 10965 **845-920-1990**
Highland Medical Breast & Women's Health Services 160 North Midland Ave Nyack, NY 10960 **845-348-8551**	**Rockland Neurological Associates** 2 Crosfield Avenue Suite 202 West Nyack, NY 10994 **845-353-4344**	**OBS-GYN of Rockland** 200 East Eckerson Road Suite 160 New City, NY 10956 **845-634-8400**
Palisades Pulmonary & Medical 2 Medical Park Drive, Suite 5 West Nyack, NY 10994 **845-727-7733**	**Advanced Cardiovascular Care** 2 Medical Park Drive, Suite 3 West Nyack, NY 10994 **845-268-0880**	**Highland Multi Specialty Clinic** 160 N. Midland Avenue, 2nd. Fl. Nyack, NY 10960 **845-897-8371**
Highland Internal Medicine 349 Route 202 Pomona, NY 10970 **845-947-1422**	**Highland Renal Group** 2 Crosfield Ave Suite 312 West Nyack, NY 10994 **845-358-2400**	**Highland Rheumatology** 2 Crosfield Avenue, Suite 315 West Nyack, NY 10994 **845-735-4114**
Highland Pulmonary Pomona 7C Medical Park Drive Pomona, NY 10970 **Tel# 845-362-1200**		

Rev. 07/31/23 NML HR

Montefiore | Nyack

Highland Medical, P.C.

TRANSAMERICA RETIREMENT SOLUTIONS
2024 VIRTUAL EDUCATION MEETING SCHEDULE

Please sign up online and learn about retirement plan elections for the 401(A) and 403(B) plans, various funding options and planning your retirement.

A representative from Transamerica Retirement Solutions will conducting virtual consultations from ***8am to 4pm***:

Tuesday, February 6th
Wednesday, March 6th
Tuesday, April 9th
Wednesday, May 8th
Wednesday, June 5th
Tuesday, July 9th
Monday, August 12th
Wednesday, September 11th
Monday, October 7th
Monday, November 11th
Monday, December 9th

To schedule an appointment on these dates, click the below link or call 319-355-3534

Make an Appointment

New York State Nurses Association

NYSNA Benefits Fund

PO Box 12430, Albany, NY, 12212-2430
(877) RN BENEFITS • www.rnbenefits.org

Summary of Benefits: Benefit Coverage Plan A

Effective January 1, 2017

	Benefit	Plan A In-Network	Plan A Out-of-Network
Financial	Deductible	None	$250 Single; $500 Family
	Maximum out-of-pocket cost (does not include charges in excess of allowed amount or noncovered benefits)	$1,000 Single; $2,000 Family copayment maximum	None
	Coinsurance	None	70%/30%
	Reimbursement rate	None	70th percentile
Preventive Care	Well-child and well-adult visits	No cost	Paid at 70% of UCR
	Well-woman visits	No cost	Paid at 70% of UCR
	Immunizations	No cost	Paid at 70% of UCR

	Benefit	Plan A In-Network	Plan A Out-of-Network
Maternity	Obstectrical, prenatal care, delivery, and postnatal care for mother	$10 copayment for initial visit only	Paid at 100% of UCR
Inpatient Care	Room and board	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%
	Physician's services	No cost	Paid at 70% of UCR
	Surgery (physician's services)	No cost	Paid at 100% of UCR
	Restorative physical and occupational therapy	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%
	Skilled nursing facility	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%
ER	At hospital emergency room (waived if admitted)	$75 copayment per visit	

	Benefit	Plan A In-Network	Plan A Out-of-Network
Outpatient Care	Office visits	$10 copayment per visit/PCP $25 copayment per visit/ specialist	Paid at 70% of UCR
	Chiropractic care*	$10 copayment per visit	Paid at 70% of UCR
	Acupuncture*	$25 copayment per visit	Paid at 70% of UCR
	Allergy treatment*	$25 copayment per visit	Paid at 70% of UCR
	Restorative physical and occupational therapy*	$10 copayment per visit	Paid at 70% of UCR
	Cardiac rehabilitation*	$25 copayment per visit	Paid at 70% of UCR
	Radiology/imaging	No cost	Paid at 70% of UCR
	Laboratory tests	No cost	Paid at 70% of UCR
	Restorative speech therapy for up to 60 consecutive days*	$10 copayment per visit	Paid at 70% of UCR
	Surgery (physician's services)	No cost	Paid at 100% of UCR
	Surgery (facility charges)	No cost	Paid at 70% of UCR

* If services are provided by a PCP (family/general practitioner, internist, OB/GYN, or pediatrician) $10 copay applies.

	Benefit	Plan A In-Network	Plan A Out-of-Network
Other Services	Physician house calls	No cost	Paid at 70% of UCR
	Skilled home health care services	No cost	Paid at 75%
	Home hospice care (up to 210 days)	No cost	Paid at 75%
	Inpatient hospice care (up to 210 days)	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%
	Durable medical equipment	Paid at 80% of cost of covered items to an unlimited maximum per participant or dependent per calendar year	Paid at 70% of covered cost of items to an unlimited maximum per participant or dependent per calendar year
	In vitro fertilization services and covered fertility drugs up to a $5,000 lifetime maximum benefit. (May elect to use the $5,000 maximum for prescriptions, if desired.)	No cost	Paid at 70% of UCR
Mental Health	Outpatient mental health care	$25 copayment per visit	Paid at 70% of UCR
	Inpatient mental health care	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%
Substance Abuse	Outpatient medical rehabilitative care for substance abuse/alcohol addiction	$25 copayment per visit	Paid at 70% of UCR
	Inpatient medical rehabilitative care for substance abuse/alcohol addiction (combined maximum for in- and out-of-network benefits)	No cost	$500 copay/admission up to $1,000 max per individual or up to $2,000 max per family (deductible does not apply) Paid at 70%

	Benefit	Plan A In-Network	Plan A Out-of-Network
Vision Care (Davis Vision)	Routine eye exam every 2 years (every year for children up to age 18)	$10 copayment per visit	Paid at up to $75 for exam and glasses or contact lenses (every 2 years)
	Eyeglasses or contact lenses every 2 years	$30 copayment for lenses and/or Designer selection frames within Davis Collection or $150 credit toward non-plan frames or $25 copay for disposable/ planned replacement lenses	

	Benefit	Plan A In-Network	Plan A Out-of-Network
Dental Care (Aetna)	Yearly deductible	None	$50/Single; $150/Family
	Maximum yearly benefit	$1,200	$1,200
	Orthodontia maximum	$1,000 per course of treatment separated by two years	$1,000 per course of treatment separated by two years
	Diagnostic and preventive services	No cost	Paid at 80% of usual and prevailing fee
	Basic restorative services, endodontics, periodontics, maintenance of prosthodontics, and oral surgery	Paid at 80% of fee schedule	Paid at 80% of usual and prevailing fee
	Major restorative services, installation of prosthodontics, and orthodontics	Paid at 50% of fee schedule	Paid at 50% of usual and prevailing fee
Prescription Drugs (OptumRx)	Maximum network out-of-pocket cost (doesn't include clinical pharmacy program penalties)	$6,150 Single; $12,300 Family	None
	Prescription drugs at retail pharmacy (up to a 34-day supply)	Tier1: $0 Generic Tier 2: $10 Preferred Tier 3: $20 Non-preferred	Reimbursed at contracted amount, minus applicable in-network copayment
	Mail-order prescription drug program (mandatory for all maintenance prescription medications for up to a 90-day supply)	Tier 1: $0 Generic Tier 2: $20 Preferred Tier 3: $40 Non-preferred	Not applicable

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

	Benefit	Benefit Coverage Plan A
Disability (The Hartford and NYSNA Benefits Fund)	Short-term, nonoccupational disability	Paid at two-thirds of regular, weekly compensation, up to $215 per week for a maximum period of 26 weeks
	Long-term disability that extends beyond the qualifying period of six consecutive months	Paid at 50% of monthly base compensation, up to $350 per month, less other disability payments, to age 65 (age 70 if disabled after age 60)
Other Insurance (The Hartford)	Life	Paid at a minimum of $20,000 and a maximum of $50,000, computed by taking 150% of current base compensation to the maximum allowable (benefit is reduced 35% at age 65, and 50% at age 70)
	Accidental death and dismemberment and loss of sight	Paid at 100% or 50% of maximum benefit, according to specific loss

MONTEFIORE NYACK HOSPITAL
160 N MIDLAND AVE
NYACK, NY 10960

unum
Better benefits at work.

Learn about your benefits: Important information inside!

Montefiore Nyack Hospital

FOR YOU FROM UNUM

Don't miss your chance:
Get valuable financial protection now!

Your benefits package is an important part of your total compensation.

Montefiore Nyack Hospital is offering you this coverage:

- Short Term Disability Insurance
- Long Term Disability Insurance

Your employer is offering coverage from Unum, a leading provider of employee benefits. You'll have the opportunity to get benefits that provide valuable financial protection now — and in the future.

Short Term Disability Insurance

can pay you a weekly benefit if you have a covered disability that keeps you from working.

How does it work?

If a covered illness or injury keeps you from working, Short Term Disability Insurance can replace part of your income while you recover. As long as you remain disabled, you can receive payments for up to 24 weeks.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

What's covered?

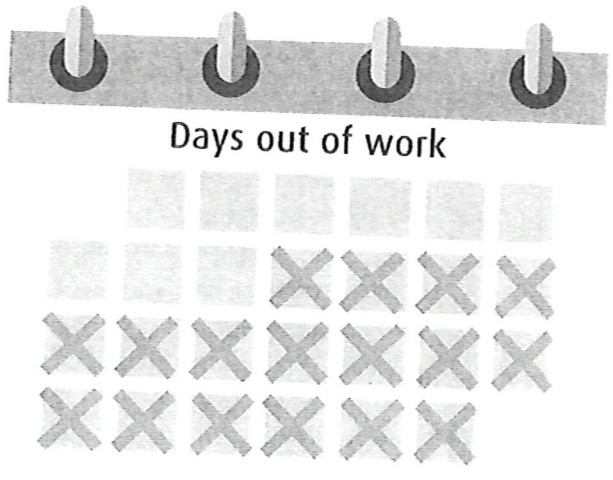
This insurance may cover a variety of conditions and injuries. Here are Unum's top reasons for short term disability claims:[1]

- Normal pregnancy
- Injuries
- Joint disorders
- Back disorders
- Digestive disorders

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

Consider your weekly expenses

Food	$_____
Transportation (gas, car payments, repairs)	_____
Child care/elder care	_____
Mortgage/rent	_____
Utilities (electric, water, cable, phone)	_____
Medical costs (co-pays, medications)	_____
Insurance (health, life, car, home)	_____
Total weekly expenses	$_____



1 Unum internal data, 2015

Short Term Disability Insurance

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of hours per week. **Coverage amounts** Cover 60% of your weekly income, up to a maximum benefit of $1,000 per week. The weekly benefit may be reduced or offset by other sources of income. *See the Legal Disclosures in the back of this booklet for more information

! If you didn't get coverage when you were first eligible, you'll have to answer medical questions now. If you're newly eligible, you are guaranteed coverage now with no medical questions. If you already have coverage, you can increase it up to the maximum available with no medical questions. New coverage may be subject to pre-existing condition limitations.

Elimination period (EP)

This is the number of days that must pass between your first day of a covered disability and the day you can begin to receive your disability benefits.

Your benefits would begin after you become disabled for 14 days.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 24 week benefit duration.

Calculate your cost

- **For step 2:**
  Enter your rate from the Rate Chart, based on your age.

  (Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date.)

Disability worksheet

1 Calculate your weekly disability benefit.

$_____ ÷ 52 = $_____ x 60% = $_____

- Your annual earnings
- Your weekly earnings
- (Max % of income covered)
- Max weekly benefit available (if the amount exceeds the plan max of $1,000, enter $1,000.

2 Calculate your cost per paycheck.

$_____ ÷ 10 = $_____ x $_____ = $_____ x 12 = $_____ ÷ 12 = $_____

- Your weekly benefit amount
- Your rate
- Your monthly cost
- Your annual cost
- Number of paychecks per year
- Your cost per paycheck

Age	Rates
<25	$0.730
25 - 29	$0.730
30 - 34	$0.730
35 - 39	$0.730
40 - 44	$0.800
45 - 49	$0.800
50 - 54	$0.880
55 - 59	$0.880
60 - 64	$0.880
65+	$0.880

Billed amount may vary slightly. Your rate is based on your age and will increase as you move to the next age band. The maximum covered annual income is $86,666.

Long Term Disability Insurance

can replace part of your income if a disability keeps you out of work for a long period of time.

How does it work?

This coverage can pay a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

What's covered?

This insurance may cover a variety of conditions and injuries. Here are Unum's top reasons for long term disability claims:[1]

- Cancer
- Back disorders
- Injuries and poison
- Cardiovascular
- Joint disorders

This plan does not cover pre-exisiting conditions. See the disclosure section to learn more.

Consider your monthly expenses

Food	$_____
Transportation (gas, car payments, repairs)	_____
Child care/elder care	_____
Mortgage/rent	_____
Utilities (electric, water, cable, phone)	_____
Medical costs (co-pays, medications)	_____
Insurance (health, life, car, home)	_____
Total monthly expenses	$_____

What else is included?

Work-life balance EAP

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

Survivor benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of premium

If you're disabled and receiving benefit payments, Unum waives your cost until you return to work.

1 Unum internal data, 2015. Note: Causes are listed in ranked order.

Long Term Disability Insurance

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of hours per week. **Coverage amounts** Cover 50% of your monthly income, up to a maximum payment of $5,000. The monthly benefit may be reduced or offset by other sources of income. *See the Legal Disclosures in the back of this booklet for more information.

! Coverage is guaranteed as long as a certain number of employees purchase coverage. If you don't sign up now but decide to apply later, you may have to answer medical questions.

Elimination period (EP)

Your elimination period is 180 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

Benefit duration (BD)

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits to age 65.

Calculate your cost

- **Use $120,000 if your annual earnings exceed this amount. This is the maximum coverage amount offered in this plan.**
- **Multiply by your rate.** Use the rate table to find the rate based on your age.

  (Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date.)

Disability worksheet

1 Enter your annual earnings and calculate your maximum monthly benefit available.

$_____	÷ 12 =	$_____	x	50% =	$_____
Your annual earnings		Your monthly earnings		(Max % of income covered)	Max monthly benefit available

2 Calculate your cost per paycheck

$_____	÷ 100 =	$_____	x	$_____ =	$_____	÷ 12 =	$_____
Your annual earnings				Rate		Number of paychecks per year	Total cost per paycheck

Age	Rates
<25	$0.140
25 - 29	$0.170
30 - 34	$0.240
35 - 39	$0.360
40 - 44	$0.590
45 - 49	$0.880
50 - 54	$1.160
55 - 59	$1.390
60 - 64	$1.380
65 - 69	$1.370
70+	$1.370

Billed amount may vary slightly. Your rate is based on your age and will increase as you move to the next age band.

Legal Disclosures

Short Term Disability Insurance

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Montefiore Nyack Hospital for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Definition of disability

You are considered disabled when Unum determines that, due to sickness or injury:
- You are limited from performing the material and substantial duties of your regular occupation; and
- You have a 20% or more loss in weekly earnings

You must be under the regular care of a physician in order to be considered disabled.
The loss of a professional or occupational license or certification does not, in itself, constitute disability.
Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Pre-existing conditions

A pre-existing condition is one for which:
- You received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and
- The disability caused by the condition begins in the first 12 months after your effective date of coverage

If you have a disability caused by, contributed to by, or resulting from your pre-existing condition,
- You will not be entitled to receive benefit payments during the first 12 months after your effective date of coverage;
- Benefit payments are not payable for such period and will not be paid at any time; and
- To receive benefit payments after such period, you must continue to be disabled and meet all other terms and conditions under the plan.

If — after your coverage effective date, but before the pre-existing exclusion period ends — you experience a disabling condition that is covered but pre-existing, you can begin receiving benefits when the exclusion period ends. But the payment period will be reduced by amount of time during which you suffered from the condition during the exclusion period.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive
- Workers' compensation or similar occupational benefit laws
- State compulsory benefit laws
- Automobile liability insurance policy
- Motor vehicle insurance policy or plan
- No fault motor vehicle plan
- Legal judgments and settlements
- Salary continuation or sick leave plans, if applicable
- Other group or association disability programs or insurance
- Social Security or similar governmental programs

Exclusions and limitations

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:
- Occupational sickness or injury - however, Unum will cover disabilities due to occupational sicknesses or injuries for partner or sole proprietors who cannot be covered by a workers' compensation law
- Intentionally self-inflicted injuries;
- Active participation in a riot;
- Participation in a felony

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:
- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan.
This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al., or contact your Unum representative.

Long Term Disability Insurance

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Montefiore Nyack Hospital for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Benefit duration (BD)

The duration of your benefit payments is based on your age when your disability occurs. Your Long Term Disability benefits are payable while you continue to meet the definition of disability. Please refer to your plan document for the duration of benefits under this policy.

Definition of disability

You are considered disabled when Unum determines that
- You are limited from performing the material and substantial duties of your regular occupation due to sickness or injury; and
- You have a 20% or more loss of indexed monthly earnings due to the same sickness or injury

After 24 months, you are considered disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
You must be under the regular care of a physician in order to be considered disabled.
The loss of a professional or occupational license or certification does not, in itself, constitute disability.
"Substantial and material acts" means the important tasks, functions and operations that are generally required by employers from those engaged in your usual occupation and that cannot be reasonably omitted or modified.
Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Pre-existing conditions

You have a pre-existing condition if:
- You received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage

If you have a disability caused by, contributed to by, or resulting from your pre-existing condition,
- You will not be entitled to receive benefit payments during the first 12 months after your effective date of coverage;
- Benefit payments are not payable for such period and will not be paid at any time, and
- To receive benefit payments after such period, you must continue to be disabled and meet all other terms and conditions under the plan.

If — after your coverage effective date, but before the pre-existing exclusion period ends — you experience a disabling condition that is covered but pre-existing, you can begin receiving benefits when the exclusion period ends. But the payment period will be reduced by amount of time during which you suffered from the condition during the exclusion period.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive:
- Workers' compensation or similar occupational benefit laws, including a temporary disability benefit under a workers' compensation law
- State compulsory benefit laws
- Automobile liability insurance policy
- No fault motor vehicle plan
- Third-party settlements
- Other group insurance plans
- A group plan sponsored by your employer
- Governmental retirement system
- Salary continuation or sick leave plans, if applicable
- Retirement payments
- Social Security or similar governmental programs

Exclusions and limitations

221182-1

First Unum Life Insurance Company, New York, New York
666 Third Avenue, Suite 301 New York, NY 10017

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form. Please be aware that any new benefit elections on this form will replace all existing elections. If you do not wish to make changes, you do not need to complete this form. Please contact your plan administrator for assistance.

Montefiore Nyack Hospital

Complete your personal information

First name (please print) | M. initial | Last name

Social Security Number | Gender | Date of birth (mm-dd-yyyy) | Original hire date (mm-dd-yyyy)

Annual salary | Hours worked per week | Occupation

Did you recently become eligible for benefits? (Y/N)

Have you been rehired by your company? (Y/N)

If so, please provide a date (mm-dd-yyyy)

Short Term Disability Insurance

421015

Choose your coverage

This plan provides a 60% benefit.

To calculate your cost per paycheck, refer to the disability worksheet under "Calculate your costs".

If you were previously eligible and didn't purchase coverage, please complete an Evidence of Insurability form. Ask your plan administrator for details.

Your actual billed amount may vary slightly.

Long Term Disability Insurance

421015

Choose your coverage

This plan provides a 50% benefit.

To calculate your cost per paycheck, refer to the disability worksheet under "Calculate your costs".

Your actual billed amount may vary slightly.

DETACH AND RETURN THIS FORM

Return forms to: Your Plan Administrator

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Underwritten by: First Unum Life Insurance Company of America, New York, New York

221182-1

STD:421015 LTD:421015

Disability Insurance — SIGN AND CERTIFY

YES — I want the disability coverage checked below	NO — I do not want disability coverage checked below
☐ I DO want **Short Term Disability Insurance**	☐ I DO NOT want **Short Term Disability Insurance**
☐ I DO want **Long Term Disability Insurance**	☐ I DO NOT want **Long Term Disability Insurance**
YES, I have read and understand the exclusions, limitations, delayed effective date, benefit reduction and offset features of my coverage as described in the enrollment materials. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change. _____ Signature ___/___/____ Date	I understand that if I elect coverage in the future, I may need to complete evidence of insurability relative to my health status in order for Unum to determine my eligibility for coverage. _____ Signature ___/___/____ Date

Caution: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This does not apply to life insurance.

Required:

First name (please print) M. initial Last name

_____ __ _____

Return forms to: Your Plan Administrator