



ORGANIZATION OF STAFF ANALYSTS WELFARE FUND

220 East 23rd Street • Suite 707

New York, NY 10010

Phone: (212) 686-1229 • Fax: (212) 686-1231

Hotline: (646) 233-5100 • www.osaunion.org

WELFARE FUND BENEFITS

Revised July 1, 2023

CONTENTS	PAGE	CONTACTS	(212) 686-1229
I. Membership	2	Forms and Questions	
II. Health Insurance	3	TO DOWNLOAD FORMS	www.osaunion.org Click on Member Services, then on OSAWF Forms
A. Superimposed Major Medical	3	Superimposed Major Medical	Michelle Rivas (212) 686-1229 or S.I.D.S. (800) 537-1238 (718) 204-7172 (516) 396-5500 www.asonef.com
1. Medical & Hospital	3	Medical/Hospital	
2. Prescription Drugs	3	Prescription Drugs	
PICA Drugs	3	Dental	
Drug Benefit for Medicare-Eligible Retirees	4	Long Term Disability	Krystal Croghan (212) 686-1229
3. Home Health Care	5	COBRA	Yolanda Milanes Vojna Stanic-Geraghty (212) 686-1229
4. Mental Health Care	6	Young Adult Dependent Coverage	
Out-patient Psychiatric Care & Counseling	6	Optical Claims	Pam Kolpan (212) 686-1229 or Davis Vision (800) 999-5431 www.davisvision.com Contact Davis Vision by phone or on the web for a full list of providers
Out-patient Substance Abuse Care	6	Basic/Optional Life Insurance	Diana Carroll (212) 686-1229
In-patient Mental Health & Substance Abuse Care	6	Medicare Drug Rider	Vojna Stanic-Geraghty (212) 686-1229
B. Audiometric (Hearing Aids & Exams)	6	Survivor Benefits	Kim Russo (212) 686-1229
III. Dental Benefits	7	Pension Counseling Appts	(212) 686-1229
A. Non-Participating Provider	7	Domestic Partners	Maria Perez (212) 686-1229
B. Participating Provider	7	Retirees	Kim Russo (212) 686-1229
IV. Optical Benefits	9	APPEALS OF CLAIM DENIALS	Trustees, OSAWF 220 E. 23 rd St Ste 707 New York NY 10010
A. Everyday Eye Care	9	Must Be In Writing To:	
1. In-Network Provider	9		
2. Out-Of-Network Provider	10		
B. Laser Vision Correction Services	10		
C. VDT Optical Benefit	11		
D. Replacement Contact Lenses By Mail	11		
E. Warranties on Davis Vision Materials	11		
V. Long Term Disability Insurance	12		
VI. Life Insurance	13		
A. Accidental Death and Dismemberment	13		
B. Member Death Benefit	13		
VII. Optional Group Insurance	13		
VIII. Survivor Benefits	14		
IX. OSAWF COBRA Continuation	14		
X. Pension Counseling	14		
XI. Miscellaneous Notes	15		
MetLife Legal, Lifestation, Domestic Partners	15		
Young Adult Dependent Coverage	15		
SLOAC and FMLA	16		
Coordination of Benefits & Appeals	16		

2023 EDITION

This year, there is a significant change to your dental benefits. We are pleased to announce that, as of July 1, 2023, the yearly plan maximum for dental coverage has increased from \$4,000 to \$5,000. The separate lifetime maximum for orthodontic treatment remains at \$4,000, in addition to the \$5,000 annual dental plan limit.

—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 17.5 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 17.5 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.

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. For example, if you belong to an HMO and use an out-of-network provider, this service might not be covered.

As of July 1, 2015, the Superimposed Major Medical Plan will cover dental work or treatment due to accidental injury, charges for some oral surgery in connection with OSA dental plan covered dental procedures that is medically necessary but not covered by the OSA dental plan, and hospital charges for certain dental extractions that can not be completed on an outpatient basis.

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 a 90% 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 the "true out-of-pocket" (TROOP) limit for drug expenses for the year 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 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, prefer-

ence 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' reach the Medicare Part D "true out-of-pocket" (TROOP) limit for the year, 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

If your Basic Medical Coverage includes:	Maximum family deductibles		
	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
- 90% 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 per ear** 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 \$5,000 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 \$5,000 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 \$5,000 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 any number of dental implants per plan year and over your lifetime, but *only within the \$5,000 annual limitation*.** In addition to implants themselves, the Fund also covers implant-related services such as custom abutments, guided tissue regeneration, abutment-supported crowns, implant-supported crowns and prefabricated abutments. If you are having implants done, please contact SIDS for information on which of the implant-related services that your dentist is considering performing will be covered by the plan.
- ▶ **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	\$4,000 lifetime maximum benefit, in addition to the \$5,000 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	any number of dental implants per plan year and over your lifetime, but <i>only within the \$5,000 annual limitation</i> .

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 (Teletypewriter) 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:**

- An eye examination, including dilation as professionally indicated.
- Tonometry (glaucoma testing)
- 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 depending 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 prescriptions, 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 ARC (anti-reflective coating – a clear coating that limits glare on the internal and external surfaces of the lens). Premium anti-reflective coating is available for an extra \$13 fee and Ultra anti-reflective coating is available for a \$25 fee;
- 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.)
- 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.
- A pair of frames selected from **the Premier selection of frames from the exclusive "Tower Collection"** in most network provider offices.

- 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 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 specified as included in the section above (if any) will also incur extra cost.
- 2) Non-Plan Contact Lenses: **If you choose contact lenses not included within the plan, a \$94 credit will be applied toward the cost of a network provider's own supply of contact lenses. In addition, the provider will charge for a contact lens fitting.**

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 Video Display Terminal 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. If you have questions about the VDT benefit, please call DavisVision. Remember that the VDT voucher is only good for 45 days from the date of issue on the voucher. **VDT glasses must be obtained from an in-network provider.**

D. REPLACEMENT CONTACT LENSES BY MAIL

DavisVision offers access to a mail order replacement contact lens service which provides a fast and convenient way to purchase replacement contact lenses. For more information, please call (855) 589-7911 or visit www.davisvisioncontacts.com. You can also call (855)

589-7910 or visit www.visionworkscontacts.com. Call and identify yourself as a DavisVision program participant. You will be asked to provide 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 one year 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 must 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.

Members normally working 30 hours or more a week may apply for long term disability benefits once they have been out sick for six months. If the claim is approved by the insurance company, the monthly benefit is \$1,000. The benefit does not cover the six month waiting period. It is paid from the date six months after your last day of work. Please contact Krystal Croghan at the union office for additional information.

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.

VI. LIFE INSURANCE

While you are a member of the OSAWF, you are covered under a group life insurance plan issued by Lincoln Life Insurance Co. 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 TERM LIFE INSURANCE

You are eligible to purchase Group Term Life Insurance through Lincoln Life Insurance Co. for yourself, your spouse, or your children. Information is available under "Member Services - Additional Benefits" on our website at www.osaunion.org or 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 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 termination deferred retirement disabled (under certain conditions)	36 months 36 months 36 months 36 months
Spouses/Partners	death of member termination of member reduction in hours of work divorce/termination of partnership deferred retirement of member disability of member (conditions apply) active military duty of a reservist	36 months 36 months 36 months 36 months 36 months 36 months during active service
Dependent Children	death of member parent termination of member parent's member parent-reduction of hours dependent no longer qualified active military duty of a reservist	36 months 36 months 36 months 36 months 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 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" and "Pension 101" seminars, the OSA Welfare Fund offers a group presentation on current pension plans and general retirement planning. The seminars review the changes that you will need to anticipate as you approach and enter retirement.

Individual pension 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 in a one-on-one session with a pension counselor, please 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 BENEFITS & NOTES

METLIFE LEGAL SERVICES PLAN

For a modest monthly premium, OSA members and retirees can enroll in a legal services plan to assist with non-employment related legal matters, including family law, real estate, elder law, and estate planning documents. For

more information, visit the “Additional Benefits” page under “Member Services” on the union website at www.osaunion.org. To enroll, contact VIP/Winston Financial at 1-800-347-6071, Monday through Friday from 8:30am - 5pm ET.

LIFESTATION MEDICAL ALERT SYSTEM

The Welfare Fund is offering a competitively priced series of options for the LifeStation medical alert system that can help protect you or a loved one who lives alone.

Members and retirees can obtain more information on the options and costs by downloading the information on our

website at www.osaunion.org on the “Additional Benefits” page under “Member Services.” If you are interested, contact LifeStation at 800-951-0634 with your questions and to arrange for service.

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.
- 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

We believe this plan is a “grandfathered health plan” under the Affordable Care Act (ACA). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage 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 ACA 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 ACA, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which 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

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 of receipt of the claim denial. Appeals must be mailed to Trustees, OSA Welfare Fund, 220 East 23rd Street, Ste 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 your family situation.
- If you have a change of title or agency.
- If you retire.
- If you change your address or phone number.
- 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 or part-time to full-time status, if hours are reduced to less than 17.5 hours or increased to more than 17.5 hours.
- If you go on sick leave.
- If you *think* you are eligible for long term disability benefits.
- If/when you become eligible for Medicare.
- If you want to purchase Group Term 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.



GENERAL®
VISION
SERVICES

YOUR IN-NETWORK VISION BENEFIT

ORGANIZATION OF STAFF ANALYSTS WELFARE FUND / BENEFIT #6028

1. WHAT YOU GET:

This is your Full Benefits Summary. Please bring it with you to your appointment. If you need any assistance, please call 888-298-9550.

Additional Eyewear Discounts:
30% off any complete pair of glasses for you or family members not covered by your plan.

For Eligibility and to Utilize Your Vision Benefit:
Simply call any of the listed providers for a convenient eye exam appointment.

Any additional services that surpass the benefit are the responsibility of the patient.

One year warranty on all Collection eyewear.

Please visit generalvision.com and enter your benefit number (6028) to receive a complete list of all your vision benefits.

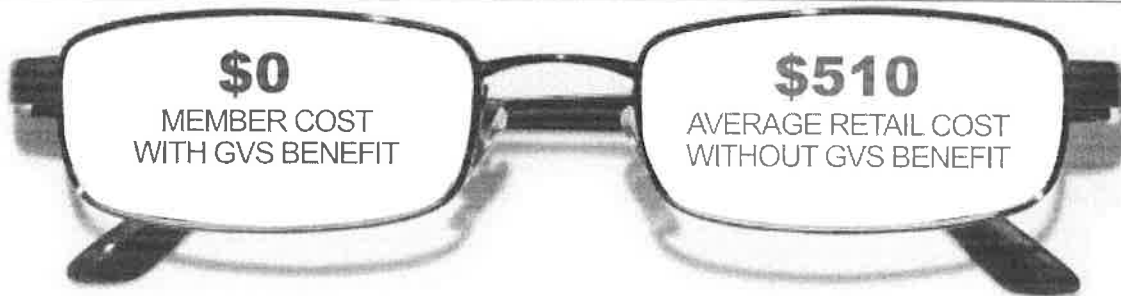
VDT: For Active Employees Only. In order to receive VDT voucher, please contact GVS directly at 888.298.9550.

VISION BENEFITS	
EYE EXAMINATION	Every 12 Months
Eye Exam (includes Dilation when professionally indicated)	Included
FRAME ALLOWANCE	Every 12 Months
GVS Collection Frame (up to \$200)	Included
Non-Collection Frame	\$150 allowance
SPECTACLE LENSES	Every 12 Months
Single Vision	Included
Bifocal	Included
Trifocal	Included
Oversize	Included
Standard Progressive	Included
Premium Progressive	Included
Deluxe Progressive	\$50 co-pay
Plastic Photosensitive Lenses (single vision)	Included
Plastic Photosensitive Lenses (bifocal)	Included
Plastic Photosensitive Standard Progressive	Included
MATERIALS	
Plastic	Included
Polycarbonate for dependent children (up to age 19)	Included
Polycarbonate	Included
High-Index	Included
Intermediate Lenses	Included
Blended Segment Lenses	Included
COATINGS	
Tints	Included
Ultra Violet	Included
Scratch Resistant Coating	Included
Premium Scratch Resistant Coating	Included
Polarized	Included
Anti-reflective - Standard Coating	Included
Anti-reflective - Premium Coating	\$13 co-pay
Anti-Reflective - Ultra Coating	\$25 co-pay
Blue Light Filtering	\$25 co-pay
CONTACT LENSES (In Lieu of Eyeglasses)	Every 12 Months
Plan Contact lenses	6 months
Plan Contact Lens Evaluation, Fitting & Follow-Up Visits	Included
Non-Plan Contact Lens (excluding colored)	\$200 allowance
Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits	\$50 co-pay



2. HOW YOU BENEFIT:

DISCOVER THE VALUE OF YOUR VISION BENEFITS		
GVS PLAN	SERVICE	AVERAGE RETAIL COST
INCLUDED	Eye Examination	\$60
INCLUDED	GVS Designer Collection Retail	\$200
INCLUDED	Standard Progressive Lenses	\$195
INCLUDED	Cosmetic or Sunglass Tint	\$30
INCLUDED	UV Coating	\$25



3. HOW YOU GET IT:

GO TO: **generalvision.com** AND DOWNLOAD THE **GVS App**

simply enter your Benefit Number 6028 to:

- FIND A PROVIDER
- SCHEDULE AN APPOINTMENT
- REVIEW YOUR BENEFITS
- VIEW VIRTUAL ID CARD

or call **888.298.9550** for more information



**Search GVS in the App store
and Register with 6028 Now!
(IOS or Android Only)**

VALUE SAVINGS**

MAIL ORDER CONTACT LENSES

1800AnyLens

15% Off

Every Contact
Lens Purchase

Promotion Code: GVS15OFF

**Call: 1-833-426-9536
or Visit: 1800anylens.com**

LASIK IS NOW EASIER FOR GVS MEMBERS!

Save 40% to 50% off* traditional LASIK services with QualSight LASIK at more than 1,000 locations nationwide. Savings also available on newer technologies such as Custom Bladeless (all laser) LASIK.

**Call 888-568-0308
for your FREE consultation.**

Visit qualsight.com/-gvs for more information.

*Savings based on overall national average price.

ADDITIONAL SAVINGS

GVS | GENERAL
VISION
SERVICES

**30% off additional eyewear
or items not covered under
your optical program**

**Call 800-VISION-1
for more information.**

** These Value added programs are included with your vision plan.



**SCHEDULE AN
APPOINTMENT**

**USE YOUR
BENEFIT**

**GVS DONATES
GLASSES**

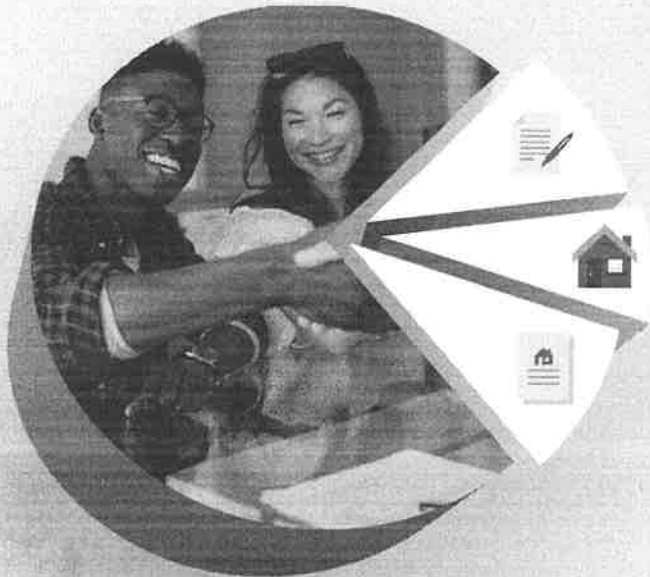
As part of our ongoing commitment to promote eye health and wellness, GVS is helping the world see clearly. Every time you take advantage of your GVS vision benefits, we'll donate a pair of glasses to someone in need.

Just by making an appointment, you can make a difference. Call us or visit our website now:

800.VISION.1 • generalvision.com

Be sure to click the "See Well, Do Good" icon to learn more about our charitable donations.





Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Legal experts on your side, whenever you need them

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.¹

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly premium of **\$19.50** conveniently paid through payroll deduction, an expert is on your side as long as you need them.

When you need help with a personal legal matter, MetLife Legal Plans is there for you to help make it a little easier.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorneys online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.²

How to use the plan

1. Find an attorney

Create an account at legalplans.com to see your coverages, select an attorney and get a case number for your legal matter. Or, give us a call at 800.821.6400 for assistance.

2. Make an appointment

Call the attorney you select, provide your case number and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

To enroll in MetLife Legal Plans, call The Voluntary Insurance Program at 800-347-6071.

Helping you navigate life's planned and unplanned events.

For **\$19.50 a month**, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

Money Matters	<ul style="list-style-type: none"> • Debt Collection Defense • Identity Theft Defense • Negotiations with Creditors 	<ul style="list-style-type: none"> • Personal Bankruptcy • Promissory Notes • Tax Audit Representation 	<ul style="list-style-type: none"> • Tax Collection Defense
Home & Real Estate	<ul style="list-style-type: none"> • Boundary or Title Disputes • Deeds • Eviction Defense • Foreclosure 	<ul style="list-style-type: none"> • Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home 	<ul style="list-style-type: none"> • Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	<ul style="list-style-type: none"> • Codicils • Complex Wills • Healthcare Proxies • Living Wills 	<ul style="list-style-type: none"> • Powers of Attorney (Healthcare, Financial, Childcare, Immigration) 	<ul style="list-style-type: none"> • Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	<ul style="list-style-type: none"> • Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance 	<ul style="list-style-type: none"> • Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection 	<ul style="list-style-type: none"> • Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	<ul style="list-style-type: none"> • Administrative Hearings • Civil Litigation Defense 	<ul style="list-style-type: none"> • Disputes Over Consumer Goods & Services • Incompetency Defense 	<ul style="list-style-type: none"> • Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: <ul style="list-style-type: none"> • Deeds • Leases 	<ul style="list-style-type: none"> • Medicaid • Medicare • Notes • Nursing Home Agreements 	<ul style="list-style-type: none"> • Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	<ul style="list-style-type: none"> • Defense of Traffic Tickets³ • Driving Privileges Restoration 	<ul style="list-style-type: none"> • License Suspension Due to DUI 	<ul style="list-style-type: none"> • Repossession



To learn more about your coverages and see our attorney network, create an account at legalplans.com

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

To enroll in MetLife Legal Plans, call The Voluntary Insurance Program at 800-347-6071.

1. You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.
2. Digital notary and signing is not available in all states.
3. Does not cover DUI.

We are pleased to announce that Metropolitan Property and Casualty (Met P&C) business has been acquired by the Farmers Insurance Group[®]. Plans provided through insurance coverage underwritten by Met P&C will transition to be underwritten by Metropolitan General Insurance Company. During the transition period, Met P&C will continue to underwrite legal plans in certain states. For additional information, please reach out to contact@legalplans.com.

Group legal plans provided by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company, Warwick, RI. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. MetLife[®] is a registered trademark of MetLife Services and Solutions, LLC, New York, NY. [MLP2]



MetLife Legal Plans | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

L0521013954[exp0822][All States][DC,PR] © 2021 MetLife Services and Solutions, LLC



**Organization of
Staff Analysts**



SHORT-TERM DISABILITY INCOME INSURANCE

Protection for Union Members

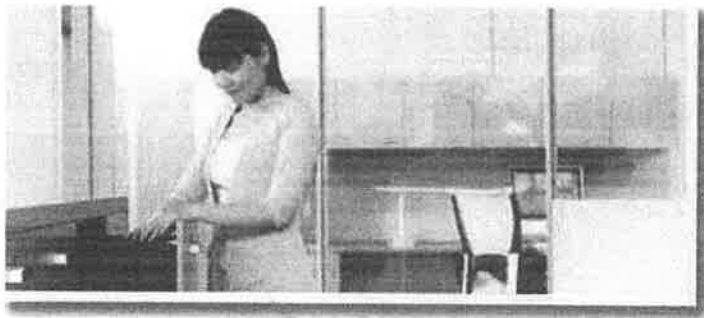
Underwritten by Transamerica Financial Life Insurance Company, Harrison, New York.

VIP PLAN ADMINISTRATOR: WINSTON FINANCIAL SERVICES, INC. 1.800.347.6071

VIP

VOLUNTARY INSURANCE PROGRAM

SUPPLEMENTAL BENEFITS FOR MEMBERS AND THEIR FAMILIES



DID YOU NEED YOUR LAST PAYCHECK?

What would happen if an injury or illness left you unable to work? Where would the money come from to pay your mortgage, rent or bills? How long would you be able to keep up with your utility bills, credit card payments, insurance premiums and other expenses?

In the end, a disability could drain your savings and other resources you have worked so hard to build – unless you have disability income insurance.

Consider these statistics:

Just over **1 in 4** of today's 20 year-olds will become disabled before they retire.¹

Over **38 million** Americans are classified as disabled; about **12%** of the total population. **More than 50%** of those disabled Americans are in their working years, from 18-64²

Roughly 76% of Americans are living paycheck-to-paycheck, with little to no emergency savings. Meanwhile, **50%** of those surveyed have less than a three-month cushion and **27%** had no savings at all.³

Fewer than five percent of disability claims were work related and would not be covered by Workers Compensation.⁴



BENEFIT FEATURES & HIGHLIGHTS

There are no physical exams or medical tests to undergo. OSA members can enroll by simply answering a few medical questions. Your application will be evaluated based upon the answers you provide. New OSA members are guaranteed acceptance regardless of their health condition provided they enroll within 6 months of receiving their OSA new membership kit - the Guaranteed issue amount is up to \$2,000 a month. New members can choose a higher amount by qualifying and answering a few medical questions. Our policy is designed to provide the following benefits for Union Members:

COVERAGE

24 hours a day, On and Off the Job

BENEFIT AMOUNT

Monthly benefits range from \$400 to \$3,000, not to exceed 50% of salary.

DURATION OF BENEFITS

Policyholders are able to collect up to two (2) years of benefits for Total Disability.

ELIMINATION PERIOD

Members can choose from a variety of waiting periods including 7, 14, 30, 90 and 180 days.

PORTABILITY

If you leave or change your job you can continue your policy by paying premiums directly to the insurance company.

GUARANTEED RENEWABLE TO AGE 65

As long as you are eligible for insurance, you have a right to renew this policy until the first premium due date on or after your 65th birthday by payment of the correct premium when due or within the grace period.

PREGNANCY

Disability resulting from pregnancy or childbirth is covered the same as any other sickness or injury, subject to preexisting condition limitations, provided the policy has been in effect for ten months or more from the effective date.

EASY PAYMENT

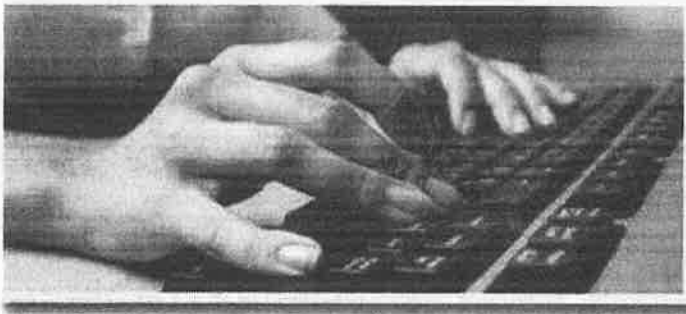
Members can elect to pay their premiums through convenient payroll deduction.

¹ U.S. Social Security Administration, Fact Sheet February 7, 2013

² Annual Disability Statistics Compendium, Disability Statistics & Demographics Rehabilitation Research & Training Center, 2013

³ Bankrate.com, 2013

⁴ Source 2013 CDA Long Term Disability Claims Review



FREQUENT QUESTIONS & ANSWERS

Q1: Who is eligible for this policy?

A1: It is available to all active union members who:
1. Work more than 25 hours per week and,
2. Are between the ages of 18 through 64

Q2: If I choose to enroll and become disabled, who will receive my benefit payments?

A2: Payment is made directly to you.

Q3: If I become disabled, do I continue premium payments?

A3: NO. After 90 days of disability, your premium payments will be waived as long as you remain eligible for disability payments.

Q4: Do I have to take a physical exam before I am approved?

A4: NO. A physical exam is not required for approval.

Q5: How will premiums be paid?

A5: The VIP program offers members the convenience of payroll deduction to pay for all premiums. There will be no checks to mail or stamps to buy.

Q6: Will my monthly benefits be reduced if I am receiving Social Security?

A6: NO. Your benefit will never be reduced regardless of other benefits received (Benefits paid under this policy may affect benefits payable under another plan).

Q7: Does the plan cover disability due to Pregnancy?

A7: YES. Pregnancy is covered the same as any covered sickness or injury provided the policy has been in effect for 10 months or more from the effective date.

RENEWAL CONDITIONS

As long as you are eligible for insurance, you have the right to renew this policy until the first premium due date on or after your 65th birthday, if you pay the current premium when due or within the grace period. Premium rates can be changed on this policy, but only by making changes to the rates for all such policies in a class. Your policy cannot be cancelled or refused to be renewed if you maintain it continuously in force.

BENEFIT WORKSHEET

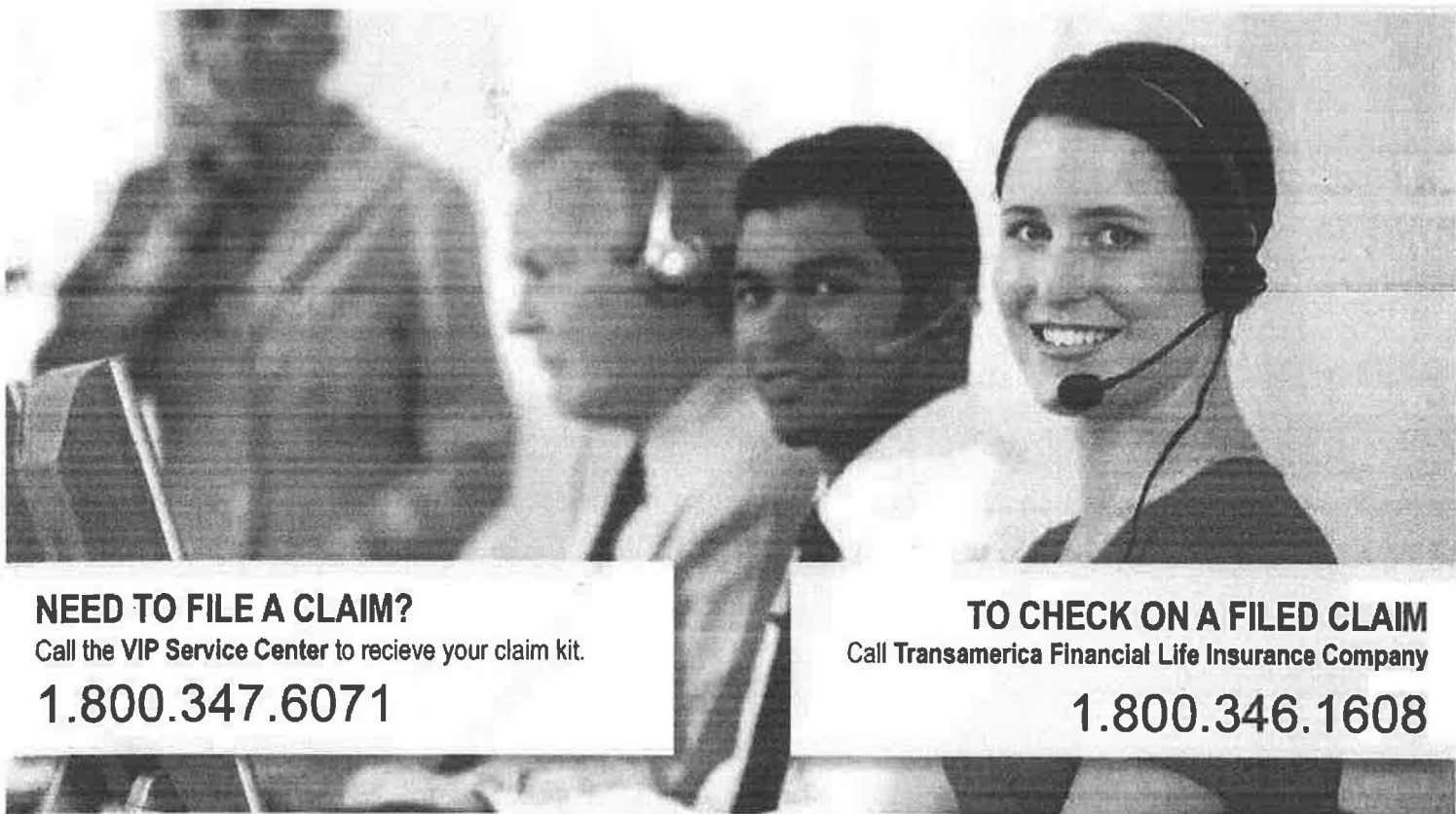
To be completed by VIP Representative

Monthly Benefit Amount \$ _____

Premium Per Pay Period \$ _____

Elimination Period _____

Benefit Duration _____ MONTHS



NEED TO FILE A CLAIM?

Call the VIP Service Center to receive your claim kit.

1.800.347.6071

TO CHECK ON A FILED CLAIM

Call Transamerica Financial Life Insurance Company

1.800.346.1608

EXCEPTIONS & LIMITATIONS

Benefits will not be paid for injury, sickness, or loss that is caused by or occurs as a result of:

- Any act of war, declared or not; participation in a riot or insurrection; or
- Intentionally self-inflicted injuries or attempted suicide; or
- Commission of or attempt to commit a felony or engaging in an illegal occupation; or
- Being intoxicated or being under the influence of any narcotic unless administered upon the advice of a physician; or
- Aviation except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; or
- Alcoholism or drug addiction; or
- A mental disorder without demonstrable organic disease

PRE-EXISTING CONDITION LIMITATION

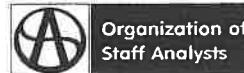
No payment will be made for loss due to a pre-existing condition if the loss is incurred or disability commences within 12 months from the effective date of coverage.

A "Pre-Existing Condition" means a condition for which:

- Symptoms existed within 12 months before the effective date of coverage; or
- Medical advice or treatment was recommended by, or received from, a physician or other member of the medical profession acting within the scope of his or her license within the 12 month period before the effective date of the policy.








VOLUNTARY BENEFITS HELP PROTECT YOUR FINANCIAL FUTURE.





At **OSA**, we want to ensure that you and your family are protected in case of an unexpected accident or illness. By enrolling in the **Voluntary Insurance Program**, you can obtain additional insurance coverage to help you meet your financial obligations and provide your family with peace of mind.

Benefit Options

-  **Voluntary Life/AD&D Insurance**
Eligible members can purchase coverage **up to \$500,000** for themselves, **up to \$30,000** for their spouse or domestic partner and **up to \$10,000** for their children.
-  **Disability**
You may have medical insurance, but what about everyday bills if you are disabled and can't work? Disability Insurance replaces a portion of your income to pay for ordinary expenses as you see fit.
-  **Accident**
Accidents are part of life, and Accident Insurance pays a benefit you can use for bills and out-of-pocket expenses if you are injured in a covered accident, beyond any other insurance.
-  **TransElite® Universal Life Insurance**
Universal Life is permanent life coverage that gives your family additional protection and lets you build cash value to use if you need it, offering more stability for you and your loved ones.
-  **Legal Assistance**
Everyone needs a little legal help now and then. MetLife Legal provides you a wide range of services with an attorney of your choice. You'll receive guidance and a course of action.

How to Enroll

-  **By Phone:**
Call 1-800-347-6071 Monday – Friday, 8:30 a.m. to 5 p.m. ET  Coverage Available for your Spouse, Domestic Partner, and Children.
Be sure to have your payroll agency number on hand.