



HOUSE STAFF BENEFITS PLAN

**Committee of Interns
and Residents**



**House Staff Benefits Plan
of the
Committee of Interns and Residents**

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A legal service benefit is provided for covered employees by the Committee of Interns and Residents Legal Services Plan (CIRLS). Telephone: (212) 356-8195.

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IMPORTANT NOTICES

This booklet describes your benefits. Do not rely on statements made by individuals. The only authorized information concerning your benefits must be in writing from the Board of Trustees acting in their official capacity and whose sole decision regarding benefits is final. If you have any questions regarding your benefits, write to the Plan Manager and you will receive a written response.

The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under this Plan and (2) the eligibility rules, including those rules providing extended or accumulated eligibility, even if the eligibility has already been accumulated.

GENERAL PLAN INFORMATION

This booklet describes the supplemental benefits provided to you through the House Staff Benefits Plan (HSBP): Accidental Dismemberment, Continuing Learning Program Reimbursement for HHC Residents, Dental Benefits, Disability-Short and Long Term, Hearing Aid Benefit, Life Insurance (Term), Life Insurance for your Spouse or Registered Domestic Partner, Major Medical (Supplemental), Mental Health Outpatient Benefit, Newborn Benefits, Obstetrical Benefit (Supplemental), QI Educational Benefits, Vision Benefit, Prescription Drug Benefit, Smoking Cessation Benefit, and Substance Abuse Counseling and Treatment Benefit for Health and Hospitals Corporation (HHC), CIR and HSBP Employers and Westchester Medical Center residents. The benefits for Cambridge Health Alliance are Vision, Dental (DentalGuard Preferred only), Disability-Short and Long Term and QI Educational Benefits. The benefits provided for the California CIR/HSBP hospitals, Modesto/Valley Consortium for Medical Education, Highland General Hospital (Alameda County Medical Center) and Santa Clara Valley Medical Center are QI Educational Benefits, Short Term and Long Term Disability with benefits and regulations as described in information provided to the California CIR/HSBP residents. The benefits provided for Los Angeles County residents are GAP Insurance and Short and Long Term Disability and QI Educational Benefits. This booklet also provides information on your HIPAA, COBRA, and other statutory benefits.

NOTICE OF GRANDFATHERED HEALTH PLAN

HSBP believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that 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 Affordable Care Act, for example, following the appeals process.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Manager at the Plan Office at 212-356-8180. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform/>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HOUSE STAFF BENEFITS PLAN

June 1, 2013

Dear Employee:

We are pleased to present you with this revised and updated booklet which describes the benefits available to you through the House Staff Benefits Plan (HSBP) of the Committee of Interns and Residents (CIR).

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

The HSBP is currently funded by employers such as the New York City Health and Hospitals Corporation (HHC) and Westchester Medical Center, Cambridge Health Alliance, CIR and HSBP employers, Modesto/Valley Consortium for Medical Education, Highland General Hospital (Alameda County Medical Center), Santa Clara Valley Medical Center, and Los Angeles County Hospitals. The HSBP receives its funds pursuant to the terms of the contract negotiated by CIR on your behalf. The contracts require your employer to make contributions to the Plan at a fixed rate per House Staff Officer.

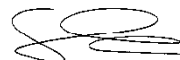
A legal service benefit is also provided for covered employees by the Committee of Interns and Residents Legal Services Plan (CIRLS). For residents employed at HHC hospitals and Westchester Medical Center, a benefit is provided for books, medical equipment and other items. The Plan is called the Professional Educational Plan (PEP). The Benefits Plan Office will supply you with these booklets.

The (HSBP) is committed to providing resident physicians the tools to deliver the best patient care. I would like to inform you of a unique opportunity to educate yourself in becoming a physician-champion in patient safety. HSBP will be funding scholarships for eligible participants to attend patient safety education and training programs in the U.S. and sponsoring QI programs.

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

The Trustees believe that your Benefits Plan will be a valuable asset to you and your family. If you have any questions regarding this material, please call, email or write the Benefits Plan Office.

Sincerely,



Sepideh Sedgh, DO.,
Chair of the Board of Trustees

Benefits Comparison Chart at House Staff Benefits Plan Hospitals

BENEFITS	HHC Hospitals ¹	Westchester Medical Center	Cambridge Health Alliance	CIR and HSBP Employers	California HSBP Hospitals ²	Los Angeles County ³
Accidental Dismemberment	√	√		√		
Continuing Learning Program	√	√		√		√
Managed Dental Guard	√	√		√		
Dental Guard Preferred	√	√	√	√		
Dental (Supplemental)	√	√		√		
Disability Short Term	√	√	√	√	√	√
Disability Long Term	√	√	√	√	√	√
GAP Insurance						√
Hearing Aid	√	√		√		
Identity Theft Monitoring and Protection Benefit	√	√		√		
Legal Services Benefit (CIRLS) ⁴	√	√		√		
Life Insurance	√	√		√		
Life Ins. Spouse or Domestic Partner	√	√		√		
Major Medical (supplemental) including Smoking Cessation	√	√		√		
Newborn	√	√		√		
Obstetrical (Supplemental)	√	√		√		
Outpatient Psychiatric	√	√		√		
PEP (Professional Education Plan) ⁵	√	√				
Prescription Drug	√	√		√		
QI Patient Safety Programs	√	√	√	√	√	√
QI Scholarship Programs	√	√	√	√	√	√
Substance Abuse	√	√		√		
Vision	√	√	√	√		√

¹ Bellevue Hospital Center, Jacobi Medical Center, Coler-Goldwater, Coney Island Hospital, Gouverneur Healthcare Services, Harlem Hospital Center, Kings County Hospital Center, Lincoln Medical Center, Metropolitan Hospital Center, Woodhull Medical Center

² Modesto/Valley Consortium for Medical Education; Highland General Hospital (Alameda County Medical Center); Santa Clara Valley Medical Center – These hospitals have their own benefits and regulations for Short-term Disability and Long-term Disability. For details, see the information distributed at your hospital.

³ A separate Summary Plan Description (information booklet) is available for LA County residents.

⁴ A separate Summary Plan Description (information booklet) is available for legal services.

⁵ A separate Summary Plan Description (information booklet) is available for professional educational services.

HSBP GENERAL BENEFITS SUMMARY

BENEFIT YEAR: July 1 through June 30		
ELIGIBILITY: Date of Hire, for specific benefits related to your employment, please review Benefits Comparison chart		
BENEFIT	EMPLOYEE	SPOUSE/DEPENDENT
CONTINUING LEARNING PROGRAM – Self-insured by HSBP		
Refer to Plan booklet for clarification on limited eligibility and Residency maximum	\$1,500 every 3 years after PGY 1	None
DENTAL – Insured by Guardian (Choice of Two Plans) / Group #G417732 / www.guardianlife.com / (888) 600-1600		
Managed DentalGuard (MDG) NOTE: Refer to the MDG chart for actual charges		
Providers Preventative & Basic Services, Major Services and Orthodontic Services Annual Maximum	Managed DentalGuard providers only Refer to Fee Schedule Unlimited	Same as employee
DentalGuard Preferred (DGP) NOTE: Dental rates below are based on average charges in NYC		
Providers In-Network Preventative & Most Basic Services In-Network Major Services In-Network Annual Maximum Out-of-Network Annual Maximum Orthodontic Services	In-Network or Out-of-Network 100% 60% \$2,000 \$1,000 60%, \$1800 Lifetime maximum	Same as employee
DENTAL (Supplemental) – Self-insured by HSBP		
Managed DentalGuard DentalGuard Preferred	Reimburses 20% of Out of Pocket costs, up to \$1,000 Reimburses 20% of Insurance Carrier payments, up to \$1,000	Same as employee Same as employee
DISABILITY, Short Term – Self-insured by HSBP		
Weekly Income Benefit Maximum Weekly Benefit	70% of basic weekly salary up to \$875 Up to 26 weeks after 7 th day	None
DISABILITY, Long Term – Insured by Guardian Group #348692		
Monthly Benefit Maximum Monthly Benefit	70% of monthly basic earnings \$3,500 up to age 65	None
GAP INSURANCE – Self-insured by HSBP		
COBRA Reimbursement	Up to \$500	Combined with employee
HEARING AID – Self-insured by HSBP; Panel of Participating Providers		
Maximum per Plan Year Participating Providers	\$5,000 per ear, per lifetime EPIC Hearing: 1.866.956.5400	Same as employee
IDENTITY THEFT MONITORING & PROTECTION – Provided by IDTSOA		
Services Provided	Monitoring of Email addresses, Bank acct & Medical ID #'s, Credit & Debit cards, phone #'s. Credit scores, reports & monitoring, SS# trace & complete identity restoration	Self-pay rate of \$6.50 per person per month
LEGAL SERVICES (CIRLS-HS) Self-insured by HSBP 212-356-8195		
Benefits offered	Free legal services for medical licensure, immigration, landlord tenant problems, family matters, consumer protection, wills, powers of attorney, estate matters, bankruptcy, credit rating, name changes, unemployment benefits, document review and criminal matters (limited coverage).	Eligible employees and dependents

HSBP GENERAL BENEFITS SUMMARY (continued)

BENEFIT	EMPLOYEE	SPOUSE/DEPENDENT
LIFE INSURANCE – Insured by Guardian Group #348692		
Term Life	\$150,000	\$20,000 (Spouse & Registered Domestic Partner only)
Accidental Dismemberment	\$50,000	None Same as employee
Ancillary Death Benefit (insured by HSBP)	Transportation of remains more than 200 miles, up to \$5,000	
MAJOR MEDICAL (Supplemental) – Self-insured by HSBP		
Co-Insurance	20% of primary carrier reimbursement	Same as employee
Co-payments & Smoking Cessation	100% *Maximum combined reimbursement per person, per plan year \$1,000	
MENTAL HEALTH OUTPATIENT (Supplemental) – Self-insured by HSBP		
Eligible providers include: M.D., PhD., EdD., PsyD., MSW, CSW or Psychiatric Nurse Practitioner	80% of the reasonable and customary provider charges, not to exceed \$200 per daily office visit	Same as employee
Annual Maximum	\$5,000	
NEWBORN (Supplemental) – Self-insured by HSBP		
Newborn Expenses, Well Baby Care, Circumcision & Childbirth Education Benefit	Combined maximum up to \$1,000 per delivery	Spouse or registered domestic partners
OBSTETRICAL (Supplemental) – Self-insured by HSBP		
Obstetrical office visits	Combined maximum up to \$1,000 per delivery	Spouse or registered domestic partners
Birth related delivery charges and deductibles		
Breast pump & accessories		
Lactation classes		
PRESCRIPTION DRUGS – Self-insured by HSBP; Express Scripts Inc. (ESI) Group #JRGA		
WMC, COBRA, CIR & HSBP Staff	Reimburse up to \$500 per benefit year	Same as employee
HHC	ESI prescription debit card, value \$500	
PROFESSIONAL EDUCATIONAL PLAN – Self-insured by PEP (see separate plan booklet)		
Work related medical books, equipment, exams, dues, journals and fees.	Up to \$650 annual benefit reimbursable at 100%; unlimited rollover	None
Mobile Electronic Medical Device	75% of device cost, refer to Plan booklet for clarification	
QI/PATIENT SAFETY EDUCATIONAL BENEFITS		
LA County	Conferences, QI Scholarship Benefit & QI Worksite Specific Curriculum	None
WMC, COBRA, CIR & HSBP Staff	QI/Patient Safety Conference & HSBP Patient Safety Edu & Training Scholarships	
VISION BENEFIT – Davis Vision, Client Code 2200, 1-877-923-2847 <small>*For LA residents refer to separate plan booklet.</small>		
In-Network: Covered in full once every plan year	Eye exam, spectacle lenses and frames or Eye exam, collection contacts & lens fitting	Same as employee
Out-of-network	Eye exam reimbursed up to \$50, materials up to \$150	

NOTE: This SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional details, contact the Benefits Plan Office and request HSBP Plan Documents.

HSBP BENEFITS ELIGIBILITY AND ENROLLMENT

Effective Date of Eligibility

You become eligible for benefits based on the day you go on your employer's payroll. HSBP covers only employees of the New York City Health and Hospitals Corporation, CIR and HSBP employers, Westchester Medical Center, and for selected benefits at Cambridge Health Alliance, Modesto/Valley Consortium for Medical Education; Highland General Hospital (Alameda County Medical Center); Santa Clara Valley Medical Center; LA County. If, during a rotation away from any of the above hospitals, you switch from that hospital's payroll to the rotation hospital's payroll, you should be aware that your HSBP benefits cease for such period and you cannot submit a claim for any costs incurred during such period. Your HSBP benefits coverage resumes on the day you return to an HSBP contributing employer payroll.

To become eligible for benefits an employee must work a minimum of 20 hours per week and contributions must be received on your behalf.

Plan Year

Plan Years are from July 1st to June 30th. You become eligible for benefits based on the day you go on your employer's payroll. *Employees who are hired during the month of June will be eligible for benefits as of their date of hire, but their plan year will run from their date of hire through June 30th of the following year.*

For example, if you are hired on June 25, 2014 your plan year will be June 25, 2014 through June 30, 2015. The following year, your plan year will be July 1, 2015 through June 30, 2016. All other eligibility and termination rules will remain the same.

Enrollment information

You and your eligible dependents are entitled to HSBP's supplemental benefits as described in this booklet. Each employer makes a contribution to the Plan on behalf of every House Staff Officer on its payroll. Therefore, the supplemental coverage is provided at no cost to you.

You must complete an **Enrollment Form** in order to be eligible for benefits from the House Staff Benefits Plan for yourself and your eligible dependents and submit it before the end of one month from your date of hire. If you do not complete an Enrollment Form and select a dental plan for yourself and your eligible dependents, you will be penalized by not being able to access all the dental services available to those residents who enrolled in a timely manner. (Domestic partners of employees employed at an HHC hospital or at WMC do not have to be enrolled with the City of New York to be eligible for supplemental HSBP benefits. However, you must complete the HSBP Eligibility Statement for Domestic Partnership. This information is kept strictly confidential.)

Dependent Eligibility

Your spouse and dependent children up to age 29 are eligible for the same benefits as you, at no cost to you, with the exception of the Continuing Learning Program, Identity Theft Protection, QI Patient Safety Conference, QI Patient Safety Education and Training Benefit, QI and Patient Safety Curriculum, PEP, Disability and Accidental Dismemberment Benefits. Term life insurance in the amount of \$20,000 is available to your enrolled spouse or registered domestic partner only.

Coverage of your eligible dependents begins on the same day your coverage begins as long as you enroll them when you complete your enrollment form and provide sufficient proof of eligibility. We will not provide benefits to your eligible dependents without a completed enrollment form and the required documents.

Your eligible dependents include:

- Your spouse
- Your dependent children
- Your registered domestic partner opposite or same sex (see below for specific details)

For the purposes of this Plan, a dependent child is any of your children (whether married or unmarried), up to their 29th birthday (end of calendar year), including:

- Your biological child;
- your legally adopted child or a child placed for adoption (placed for adoption assumes retention by the Participant of a legal obligation for total or partial support of such child in anticipation of adoption);
- a step-child or foster-child;
- your domestic partner's child
- an unmarried individual whom the employee has legal guardianship under a court order and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the Internal Revenue Code Section 152(c) or 152(d) OR who will be claimed as a dependent on the employee's tax return each plan year for which coverage is provided;
- A child named as an "alternate recipient" under a Qualified Medical Child Support Order.

A spouse or child of a Dependent Child is not eligible for coverage under the Plan.

Coverage for dependent children will not terminate for unmarried disabled children regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law), or physical handicap, and who became disabled prior to reaching the age limit of the Plan. Such coverage shall not terminate while the employee's coverage remains in effect, and the dependent remains disabled and is chiefly dependent on the employee for support and maintenance. The employee must submit proof of such dependent's incapacity within 31 days of dependent's attainment of age limit.

Enrolling Eligible Dependents

To enroll your spouse, you must complete an enrollment form and provide your spouse's name, social security number, and provide a copy of your marriage certificate or IRS Form 1040.

To enroll your dependent children, you must complete an enrollment form and provide their name, social security number, and attach a copy of their birth certificate or adoption/guardianship papers for children whom you have adopted or are legal guardian. For stepchildren, you also need to provide a copy of your marriage certificate between you and the children's parent.

Domestic Partners

To enroll your domestic partner, you must complete an Eligibility Update form **and** a Domestic Partnership Application furnished by HSBP. If you do not enroll your domestic partner during your initial enrollment in the Plan, you will be able to enroll them during one of the two open enrollment periods (described later). You must provide proof that you are registered as domestic partners in the City of New York or documentation of shared financial responsibility. The domestic partnership application must be signed by both partners and notarized. By law you are responsible for paying taxes on the value of your domestic partner benefit. You will be notified of the amount by your employer. The value of your domestic partner benefits are approximately \$1,000 per year.

BASIC HEALTH INSURANCE

You are also eligible for basic health insurance, which is provided by the hospital at which you are employed, under the contract between the Committee of Interns and Residents (CIR) and your

employer. Enrollment for this basic insurance is your responsibility; you should check with the hospital's personnel office at the beginning of each contract year to verify that your insurance is still in effect.

The basic health insurance plan is considered your primary insurance and insures not only you, but also your eligible dependents (i.e., your spouse, your domestic partner, and eligible dependent children).

DENTAL PENALTY

The penalties for failure to enroll within one month of residency include access only to preventative and some basic services in the first 12 months of enrollment. You and your eligible dependents will not be able to utilize major services such as crowns or complex molar root canal therapy until after your first 12 months of enrollment. You will not be able to use the orthodontic services until after you have been enrolled for 24 months. **We urge you to complete your Dental Application and to select your dental plan as soon as possible.**

HSBP INSURED BENEFITS

Most HSBP benefits are insured by the Plan itself. They are: Accidental Dismemberment, Childbirth Education, Continuing Learning Program, Dental (supplemental), Newborn Benefit, Outpatient Psychiatric Benefit, Prescription Drug Benefits, QI Educational and Conference Reimbursement, Smoking Cessation, Supplemental Major Medical, Short-Term Disability, Supplemental Obstetrical, Substance Abuse Counseling and Treatment, Vision Benefits,.

Guardian Life Insurance Company insures the following benefits: Dental Benefit, Long-Term Disability, Life Insurance (Term) and Life Insurance (Term) for Your Spouse or Registered Domestic Partner.

PROCEDURE FOR FILING CLAIMS

1. Make sure your enrollment form is on file with up-to-date information.
2. Download claim forms before you have services rendered at <http://www.cirseiu.org>
3. Provide all the information requested, enclose all bills and relevant documents with the claim forms
4. Keep copies of all material sent to the Benefits Plan office.
5. Submit the completed forms to the Benefits Plan office within one year of the date of purchase or continuing learning program attendance.

Forms and information may also be obtained from the Benefits Plan Office. Call or write House Staff Benefits Plan, 520 Eighth Avenue, Suite 1200, New York, New York 10018, Telephone: (212) 356-8180, Fax: (212) 356-8181, E-Mail: benefits@cirseiu.org.

CHANGE IN FAMILY STATUS

This Plan does not provide prescription, basic hospital, basic or major medical insurance as defined by the New York State Insurance Department. These benefits are provided through the hospital where you are employed. You must notify your employer with any change in family status.

You must notify the Benefits Office within 31 days and in writing (by completing Eligibility Update form) when you have a change in family status and/or want to change your life insurance beneficiary. A change in family status occurs when:

- You get married.
- You commence a qualified domestic partnership relationship.
- A child is born, adopted or placed for adoption.
- A death occurs in your family.

- You are legally separated, divorced, your marriage is annulled, or you terminate your domestic partnership relationship.
- Your dependent child is legally separated, divorced, or their marriage is annulled.

Other Changes

You should notify the HSBP Office within 31 days and in writing when any of the following occurs:

- You change your name.
- You change your address.
- You move out of your health or dental plan's coverage area.
- You receive or change your Social Security Number.
- Your dependent child reaches the Plan's age limit for dental and vision benefits but is enrolled as full-time student or has a change in school status.
- Your dependent child becomes physically or mentally handicapped.
- You or your eligible dependent becomes enrolled in, or loses coverage under Medicare.
- You or your eligible dependent becomes enrolled in, or loses coverage under another medical or dental plan.
- Social Security disability benefits are awarded or terminated for you or your eligible dependent.

All changes in status require copies of the appropriate documents to be attached to the enrollment form before returning to the Plan.

OPEN ENROLLMENT

This Plan has an open enrollment period twice each year on January 1st and July 1st. The enrollment for most participants is July 1st. However, if you have not enrolled yourself and/or your dependents when you are first eligible for coverage within 31 days of your hire date, you may enroll yourself and your eligible dependents during either of the open enrollment periods. During open enrollment, you will also be able to switch between dental options.

Opt-Out

- If you, the Participant, elect not to participate in the HSBP you will be opting-out of **ALL** your benefits for yourself and all your eligible dependents. You will be required to complete an Opt-Out Form and provide proof of other coverage. Remember, that a dependent may not be enrolled for coverage unless you (the employee) are also enrolled.
- If you elect not to cover your dependents under the HSBP they will be opting-out of **ALL** their benefits. If you initially enrolled your dependent(s) and later wish to dis-enroll any or all of your dependents, your dependent(s) will be required to complete an Opt-Out Form and provide proof of other medical coverage.
- If, at a later date, you want the coverage you declined for yourself and/or your dependents, you may enroll only under the special enrollment provisions described below or during the open enrollment periods in January and July of each year.
- Note that no additional compensation is paid to you if you waive/decline benefit coverage.

Special Enrollment

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future enroll yourself and/or dependents in this Plan, if you request enrollment within 31 days from the date their or your previous coverage ends (or the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 31 days from the date of marriage, birth, adoption, or placement for adoption.

If you did not enroll yourself or your dependents in the Plan when first eligible, you may enroll yourself or your dependents if they have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and lose eligibility for that coverage. In addition, you may also enroll yourself and/or your dependents in this plan if you and/or they become eligible for a premium assistance program through Medicaid or SCHIP. However, you must request enrollment within 60 days after the loss of coverage through Medicaid or SCHIP or eligibility for a premium assistance program through Medicaid or SCHIP.

To request special enrollment or obtain more information, contact:

House Staff Benefits Plan
520 Eighth Avenue, Suite 1200, New York, New York 10018
Phone: (212) 356-8180 Fax: (212) 356-8181
Email: benefits@cirseiu.org

TERMINATION AND EXTENSION OF COVERAGE

Termination of Coverage: When Coverage Ends

Your coverage ends on the last day of the month in which:

- your employment ends; or
- you are no longer eligible to participate in the Plan; including but not limited to Off-payroll rotations to a hospital not covered under HSBP

Coverage of your covered dependents ends on the last day of the month in which:

- your own coverage ends; or
- your covered spouse or dependent children no longer meet the definition of spouse or dependent children.

Your coverage may be terminated retroactively (rescinded) due to any of the following:

- in cases of fraud or intentional misrepresentation
- due to non-payment of premiums (including COBRA premiums)

In all other cases, the Plan will provide you with a 30-day advance written notice prior to the date of the rescission of your coverage.

Failure to provide complete, updated and accurate information to the Plan Office on a timely basis regarding your marital status, employment status of a spouse or child, the existence of other coverage or, in the case of adult children, eligibility for other employer-sponsored coverage constitutes intentional misrepresentation of material fact to the Plan.

You, your Spouse, or any of your Dependent Children **must notify the Plan no later than 60 days after**:

- The date your Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce);
- The date on which your Dependent Child ceases to meet the Plan's definition of Dependent (such as when the Dependent Child reaches the Plan's limiting age or the Dependent Child ceases to have any physical or mental handicap);

Failure to give the Plan timely notice will cause your Spouse, and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental handicap. If you fail to provide notice to the Plan and your Dependent(s) remains covered, you will be responsible for reimbursing the Plan for any claims or any premiums that are paid on behalf of your dependent child, spouse, or domestic partner who is no longer an eligible Dependent.

If you have questions about the definitions used in this section, please refer to the section on Eligibility earlier in this book, or call the Plan Office.

Certificate of Creditable Coverage

When your coverage ends you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time you and/or your dependents were covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law. This certificate may

be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy within 63 days after your coverage under this Plan ends.

The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents under the new group health plan or health insurance policy. Call or E-Mail the Benefits Plan Office for information regarding COBRA (Phone: 212-356-8180 or benefits@cirseiu.org).

This certificate will be provided to you shortly after the Plan knows, or has reason to know, that coverage (including COBRA coverage) for you and/or your covered dependents has ended.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered dependents) elect COBRA coverage, another certificate will be sent to you (or them if COBRA coverage is provided only to them) by first class mail shortly after the COBRA coverage ends for any reasons.

You can also contact the Plan to receive a copy of this certificate, provided that the Plan Office receives the request within two years after the later of the date your coverage under this Plan ended or the date your COBRA coverage ended.

Please address all requests for Certificates of Creditable Coverage to:

House Staff Benefits Plan Office
520 Eighth Avenue, Suite 1200, New York, New York 10018
Phone: (212) 356-8180, Fax: (212) 356-8181
benefits@cirseiu.org

Extension and Continuation of Coverage

Your Plan does not provide benefits for any expenses incurred after coverage ends. However, under certain circumstances:

- Your medical and dental coverage may be extended for certain expenses incurred after coverage ends; and
- Your medical and dental coverage may be continued for a limited period of time under certain circumstances.

Refer to sections on COBRA Continuation Coverage, Family and Medical Leave, Extension and Continuation of Coverage under Disability, and USERRA for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A Qualified Medical Child Support Order is a court judgment, decree or order that creates or recognizes the rights of a child, also called the “alternate recipient,” to receive benefits under a group health plan. The QMCSO typically:

- Designates one parent to pay for a child’s health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent’s health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type of benefit that the Plan does not otherwise provide, except as required by a state’s Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If the Plan determines that the Order is a QMCSO, and if the employee is covered or eligible for coverage by the Plan, the parents and each child will be advised of the procedures to follow in order to provide coverage to the Dependent Child(ren).

Enrollment Related to a Valid QMCSO

If the Plan determines a QMCSO is valid, it will accept enrollment of the alternate recipient as of the earliest date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.

- If the employee is already a Participant, the QMCSO may require the Plan to provide coverage for the employee’s dependent child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received.
- If the employee is not a Participant when the QMCSO is received and the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received.
- Coverage will be subject to all terms and provisions of the Plan, including any exclusion of pre-existing conditions, limits on selection of provider and requirements for authorization of services, as permitted by applicable law.

Generally coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under

the Plan for other dependent children. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. For COBRA eligibility and enrollment requirements, see the COBRA section of this document.

For additional information regarding the Plan's procedures for administration of QMCSOs, contact the Benefits Office.

FAMILY MEDICAL LEAVE ACT (FMLA)

If you have completed 12 months of employment, you are entitled by law up to 12 weeks each year of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth or adoption or placement with you for adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. While you are officially on such a Family or Medical Leave, you can keep your medical and dental coverage in effect during that period.

You are generally eligible for a Family or Medical Leave if you work at a location where at least 50 employees are employed by the employer within 75 miles.

Your plan coverage will remain until the end of the leave, provided your employer properly grants the leave and makes the required notification to the Plan.

Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that Leave, your medical and dental coverage will be reinstated without any additional limits or restrictions imposed on account of your Leave. This is also true for any of your dependents who were covered by the Plan at the time you took your Leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that Leave will apply to you and your dependents in the same way they apply to all other employees and their dependents.

Health Coverage While on Leave

To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Human Resources Department. To find out more about your benefits during Family and Medical Leave, contact the Plan Office.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

- **If your coverage ends while you are on an approved leave of absence for family, medical or military leave**, your coverage will be reinstated on the first day of the month following your return to active employment, if you return within 14 days after your leave of absence ends, subject to all accumulated Overall and Annual Maximum Benefits that were incurred prior to the leave of absence.
- **If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave**, your coverage will be reinstated on the first day of the month following your return to active employment, if you return immediately after your leave of absence ends, subject to any Overall and Annual Maximum Plan Benefits that were incurred prior to the leave of absence.

Any period of any approved leave of absence, including a leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act, will **not** be counted as a Break in Coverage. Questions regarding your entitlement to an approved leave of absence and to the continuation of medical and dental coverage should be referred to your employer.

ACCIDENTAL DISMEMBERMENT BENEFIT

(This Benefit is insured through HSBP)

This benefit will be paid for any of the following losses as the result of an accident occurring on or off the job while you are insured. The injury must have resulted in the loss directly and independently of all other causes and the loss must have occurred within 90 days after the injury was sustained. It is payable in addition to any other insurance for which you may be eligible.

All benefits are payable to you, except that any benefit unpaid at your death will be paid to your beneficiary or beneficiaries.

For Loss of:

Both hands,	Full Amount of Insurance (which is \$50,000 paid to you)
Both feet,	
Sight of both eyes,	
One hand and one foot,	
One hand and sight of one eye, One foot and sight of one eye	

For Loss of:

One hand,	One-Half of the Amount of Insurance (which is \$25,000 paid to you)
One foot,	
Sight of one eye	

- Loss of sight means total and irrevocable loss of sight. Loss of a hand or foot means loss by severance at or above the wrist or ankle.
- The total payment for all losses due to any one accident will not be more than the full amount of the benefit.

Exclusions

The Accidental Dismemberment Insurance does not cover:

- any loss resulting from war or any act of war (including undeclared war and resistance to armed aggression);
 - attempted suicide;
 - any loss which results directly or indirectly from bodily or mental infirmity or disease or medical or surgical treatment for such;
 - any loss which results from an infection other than a pyogenic infection of an accidental cut or wound;
 - any loss which results from travel in any moving aircraft aboard which you are giving or receiving training or have any duties.
-

CONTINUING LEARNING PROGRAM REIMBURSEMENT BENEFIT

(This Benefit is insured through HSBP)

Effective July 1, 2014, the Plan will reimburse for the **Continuing Learning Program (formerly known as Conference Reimbursement)**:

Residents and fellows a maximum of \$1,500 every three years based solely on their paid PGY level.

PGY level	Maximum reimbursement
1-3	\$1,500
4-6	\$1,500
7-9	\$1,500

All fellows who were on HHC or WMC payroll as of 6/1/2014 will be grandfathered to receive \$1,500 per year as long as they remain on HHC or WMC payroll. **No resident or fellow can receive more than the maximum allowable amount of \$1,500 during any Plan Year. However, said maximum may be split among one or more continuing learning programs during your basic residency, or during each fellowship or chief residency year.**

- Eligible programs are medical conferences, board review courses, and/or online courses
- ATLS, PALS, ACLS as well as CD-Rom or DVD Board Review Courses are NOT covered expenses under continuing learning program benefit.

You must request the reimbursement within 1 year from the date of payment for the continuing learning program. Claim forms can be downloaded from our website (www.cirseiu.org), and must be accompanied by proof of attendance and receipts for any eligible expenses to be reimbursed. If the hospital where you are employed also provides this benefit, the employer will reimburse you first and the Plan will reimburse you for the balance, up to a maximum of \$1,500 for any outstanding balance.

Continuing learning programs attended after you terminate your residency program are covered if you pay for the continuing learning program while on your hospital's payroll and attend the continuing learning program within 6 months of termination. You must still provide documentation illustrating proof of attendance.

Rotations between a CIR hospital and a non-CIR hospital should be paid for and attended while on HHC or WMC payroll. If attendance or payment is not possible for the House Staff Officer because of a rotation schedule, a written appeal outlining the facts should be addressed to the Board of Trustees.

How to File Your Claim

In order to apply for reimbursement of continuing learning program expenses you must:

- Submit all eligible expenses to the hospital where you are employed and retain two copies, one for your records and one to submit to the Benefits Plan Office.
- Eligible expenses are defined as Registration/Tuition, Lodging/Hotel, Meals (for continuing learning programs away from home) are reimbursed for a maximum of \$10 for breakfast, \$20 for lunch and \$30 for dinner each day), travel (i.e. planes, cabs, tolls, gas, telephone and other necessary expenses). Receipts must be submitted for all expenses claimed, **including meals.**
- Copies of receipts will be accepted as proof of expense. Original receipts may be requested.

- Submit one form per continuing learning program. Attach receipts for expenses only up to the maximum reimbursable limit.
- Reimbursement for meals, travel and lodging will not be reimbursed without proof of registration and attendance at a continuing learning program. No claims will be processed prior to attendance at a continuing learning program or prior to date of online course/board review.
- Continuing Learning Program agenda or program must also be attached. Copy acceptable.
- All claims must be submitted to our office within one year from the payment date of the continuing learning program. Claims submitted after one year will be denied.
- If a payment is received from the hospital, submit a copy of the claim, a copy of the check, the appropriate HSBP claim form and all receipts.

THIS BENEFIT COVERS ONLY EMPLOYEES OF THOSE ELIGIBLE HOSPITALS
Refer to Chart “Benefits at House Staff Benefits Plan Hospitals” for details.

DENTAL BENEFITS

(Insured by Guardian Dental Insurance – Group #417732)

SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional details, call the Benefits Office and ask for the HSBP Plan Documents.

The dental coverage for all House Staff Benefits Plan employees and dependents eligible for dental coverage will be through Guardian Life Insurance Company. All New York State House Staff residents have a choice between a Managed DentalGuard or DentalGuard Preferred. Cambridge Health Alliance residents only have the option of DentalGuard Preferred. The following is a summary of the benefits offered by each Plan:

DENTAL EXPENSE COVERAGE

Guardian Life Insurance Company administers the dental plan which has two options from which you can choose for yourself and your eligible dependents. Managed DentalGuard (MDG) is a Dental Managed Organization plan which functions much like an HMO does for health care. The optional plan is called DentalGuard Preferred (DGP) which is a Preferred Provider Organization which will allow you to use either a dentist who is participating in the plan or any dentist you choose, whether or not he or she is participating in the plan with Guardian. **You must choose one Plan, either Managed DentalGuard or DentalGuard Preferred.**

Either plan will cover many of the dental expenses incurred by you and those of your dependents who are covered for dental benefits under this plan. However, the most economical plan for you and your dependents will be the Managed DentalGuard, while the DentalGuard Preferred plan will allow you greater choice of dentists. If you chose the DentalGuard Preferred plan, your costs will be less if you choose dentists who are participating in the network over those who are not.

Guardian decides: (a) the requirements for services to be paid; and (b) what benefits are to be paid by either plan. Guardian also interprets how the plan is to be administered. What Guardian covers and the terms of coverage are explained below.

Managed DentalGuard (MDG) This plan is designed to provide quality dental care while controlling the cost of such care. To do this, this plan requires members to seek dental care from participating dentists that belong to the MDG network. Except for emergency dental services, in no event will Guardian pay for dental care provided to a member by a non-participating dentist.

The MDG network is made up of participating dentists in a member's geographic area. A "participating dentist" is a dentist that has an MDG participation agreement in force with Guardian.

When a member enrolls in this plan, he or she will get information about Guardian's current participating general dentists. Each member must select from this list of participating general dentists a primary care dentist (PCD) who will be responsible for coordinating all of the member's dental care. If a member does not select a dentist for themselves or eligible dependents, they will automatically be defaulted to the provider closest to their home address. **If a member's address is outside of the tri-state area they must select a PCD within the tri-state area or select the Dental Guard Preferred plan. Guardian cannot automatically default you to the provider closest to your home address.** If a member does not complete an enrollment form within thirty days from their date of hire, they will only be able to select the MDG plan until the next Open Enrollment Period. After enrollment, a member will receive a MDG ID card. A member must present this ID card when he or she goes to his or her PCD. All dental services covered by this plan must be coordinated by the PCD whom the member selects and is assigned to upon enrolling in this plan. What Guardian covers is based on all the terms of this plan. Read this plan carefully for specific benefit levels, exclusions, coverage limits and patient charges.

Choice of Dentists

A member may select any available participating general dentist as his or her PCD. A request to change PCDs must be made to Guardian. Any such change will be effective the first day of the month following approval. Guardian may require up to 30 days to process and approve any such request. All fees and patient charges due to the member's current PCD must be paid in full prior to such transfer.

Guardian compensates participating general dentists through an advance payment agreement by which they are paid a fixed amount of money each month based upon the number of members that select them as their PCD. In addition, Guardian may make supplemental payments on a limited number of specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the participating general dentist receives from Guardian. The dentists also receive compensation from plan members who may pay an office visit charge for each office visit and a defined patient charge for specific dental services. The schedule of patient charges is shown below.

Specialty Referrals

A member's PCD is responsible for providing all covered services. However, certain services may be eligible for referral to a participating specialist. Guardian will pay for covered services for specialty care, less any applicable patient charges, when such specialty services are provided in accordance with the specialty referral process described below.

Guardian compensates our participating specialists the difference between their contracted fee and the patient charge shown in the Covered Dental Services and Patient Charges section. This is the only form of compensation that participating specialists receive from Guardian.

ALL SPECIALTY REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY GUARDIAN; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

Emergency Dental Services

Guardian provides for emergency dental services twenty-four hours a day, seven days a week, to all members. A member should contact his or her selected and assigned PCD, who will make arrangements for such care. If a member is unable to reach his or her PCD in an emergency during normal business hours, he or she must call our Member Services Department for instructions. If a member is unable to reach his or her PCD in an emergency after normal business hours, the member may seek emergency dental services from any dentist. Then, within 2 business days, the member should call Guardian to advise of the emergency claim. The member must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her PCD. This must be done within 90 days, or as soon as is reasonably possible. We will reimburse the member for the cost of the emergency dental services, less any patient charge which may apply.

Out-Of-Area Emergency Dental Services

If a member is more than 50 miles from his or her home and emergency dental services are required, he or she should seek care from a dentist. Then he or she must file a claim within 90 days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating dentist. The statement must list all services provided. We will reimburse the member within 30 days for any covered emergency dental services, up to a maximum of \$50.00 per incident, after payment of any patient charge which may apply.

Covered Dental Services and Patient Charges - Plan 6NY0G

The services covered by this Plan are named in the following list. If a procedure is not on this list, it is not covered. All services must be provided by the Member's PCD.

The Member must pay the listed Patient Charge. Guardian covers the rest of the Participating Dentist's charge for the service. The benefits Guardian provides are subject to all the terms of this Plan, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions. These Patient Charges are only valid for covered services rendered by Participating Dentists in the State of New York.

Alternative Procedures

General Guidelines for Alternative Procedures

There may be a number of accepted methods of treating a specific dental condition. When a member selects an alternative procedure over the service recommended by the PCD, the member must pay the difference between the PCD's usual and customary charge for the recommended service and the alternative procedure. He or she will also have to pay the applicable patient charge for the recommended service.

When the PCD recommends a crown, the alternative procedure policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The member must pay the applicable patient charge for the crown actually placed. The member must pay the added cost of high noble metal, if high noble metal is selected.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the member before treatment begins. The PCD should present the Member with a treatment plan in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional details, call the Benefits Office and ask for the HSBP Plan Documents.

DentalGuard Preferred (DGP) - This Plan's Dental Preferred Provider Organization

DentalGuard Preferred is the alternate plan to Managed DentalGuard. DentalGuard Preferred is a Preferred Provider Organization which allows the member and eligible dependents greater freedom in choice of dentists, but will also incur greater costs for the services rendered. This plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the plan encourages a covered person to seek dental care from dentists and dental care facilities that are under contract with Guardian's dental preferred provider organization (PPO).

This plan usually pays a higher level of benefits for covered treatment furnished by a preferred provider. Conversely, it usually pays less for covered treatment furnished by a non-preferred provider.

The DentalGuard Preferred is made up of preferred providers in a covered person's geographic area. Use of the DentalGuard Preferred is voluntary. A covered person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

When an employee enrolls in this plan, he or she and his or her dependents receive a dental plan ID card and information about current preferred providers.

A covered person must present his or her ID card when he or she uses a preferred provider. Most preferred providers prepare necessary claim forms for the covered person, and submit the forms to Guardian. Guardian sends the covered person an explanation of this plan's benefit payments, but any benefit payable by Guardian is sent directly to the preferred provider.

What Guardian pays is based on all of the terms of this plan. Please read this plan carefully for specific benefit levels, deductibles, payment rates and payment limits.

A covered person may call Guardian at the number shown on his or her ID card should he or she have any questions about this plan.

COVERED CHARGES

If a covered person uses the services of a preferred provider, covered charges are the charges listed in the fee schedule the preferred provider has agreed to accept as payment in full, for the dental services listed in this plan's List of Covered Dental Services.

If a covered person uses the services of a non-preferred provider, covered charges are reasonable and customary charges for the dental services listed in this plan's List of Covered Dental Services.

To be covered by this plan, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

Guardian may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By "reasonable," Guardian means the charge is the dentist's usual charge for the service furnished. By "customary," Guardian means the charge made for the given dental condition isn't more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this plan, these less extensive procedures are considered to be part of the more comprehensive

procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, Guardian may only pay benefits for the osseous surgery.

Guardian only pays benefits for covered charges incurred by a covered person while he or she is insured by this plan. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, Guardian will only pay benefits for services which are completed within 31 days of the date his or her coverage under this plan ends. These are sample rates by percentage:

DGP COVERED CHARGES

- **Preferred Provider Organization (Benefit Year Cash Deductible for Non-Orthodontic Services)**
For Group I, II and III Services None
- **Non-Preferred Provider Benefit Year Cash Deductible for Non-Orthodontic Services**
For Group I Services¹ None
For Group II and III Services \$25.00
for each covered person
- **Payment Rates for Services Furnished by a Preferred Provider:**
For Group I Services 100%
For Group II Services² 100%
For Group III Services³ 60%
For Group IV Services⁴ 60%
- **Payment Rates for Services Not Furnished by a Preferred Provider:**
For Group I Services 100%
For Group II Services 80%
For Group III Services 50%
For Group IV Services 60%
- **Preferred Provider Benefit Year Payment Limit for Non-Orthodontic Services**
For Group I, II and III Services Up to \$2,000.00
- **Non-Preferred Provider Benefit Year Payment Limit for Non-Orthodontic Services**
For Group I, II and III Services Up to \$1,000.00
- **Lifetime Payment Limit for Orthodontic Treatment**
For Group IV Services Up to \$1,800.00

¹**Group I Services (Basic Services)** include prophylaxis and fluoride treatments, office visits, examinations and evaluations, X-rays and dental sealant treatments.

²**Group II Services (Basic Services)** include diagnostic services, restorative services, crown and prosthodontic restorative services, endodontic services, periodontal services, periodontal surgery, non-surgical extractions, surgical extractions and other surgical services.

³**Group III Services (Major Services)** include major restorative services and prosthodontic services.

⁴ **Group IV Services** – orthodontic services.

Alternative Treatment

Alternate Treatment

If more than one type of service can be used to treat a dental condition, Guardian has the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by Guardian. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See the following:

MAXIMUM ROLLOVER PROVISIONS APPLYING ONLY TO DENTALGUARD PREFERRED MEMBERS

Maximum Rollover: With Maximum Rollover, Guardian will roll over a portion of each member's unused annual maximum, called the Maximum Rollover Amount, into his or her Maximum Rollover Account (MRA). The MRA can be used in future years, if a member reaches the plan's Annual Maximum. Maximum rollover does not apply to Orthodontic Services.

Even better, if a member uses the services of Preferred Providers exclusively during the benefit year, we'll increase the amount credited to his or her MRA to the In-network Only Maximum Rollover Amount.

To qualify, a member must submit a claim and not exceed the paid claims Threshold during the benefit year. The employee and each insured dependent maintain separate MRAs based on their own claim activity. Each member's MRA may not exceed the MRA limit.

PLAN ANNUAL MAXIMUM	THRESHOLD	MAXIMUM ROLLOVER AMOUNT OUT OF NETWORK	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLL-OVER ACCOUNT LIMIT
\$1000	\$500	\$250	\$350	\$1000

- An employee joining the plan as a new entrant with 3 months or less remaining in the benefit year: the MRA accumulation will begin as of the first full benefit year. (Example: An Employee joining in November of 2008, claim activity in 2009 will be used and applied to MRAs for use in 2010).
- Children are covered up to age of 29.
- Your non-network service charges will be paid for only up to the maximum fee level established with our contracted network dentists. Any amount that is charged over the fee schedule is the responsibility of the patient.
- Dental Claims - P. O. Box 2459, Spokane, WA 99210-2459, ph: 1-800-541-7846, fax: 509-468-4590.
- Guardian has contracted with dental providers to provide discounts off services and procedures to Guardian dental plan members. To locate a provider, please reference the On-Line Provider Directory at www.GuardianLife.com.
- Pre-determination Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over \$300. Have your dentist fax

your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable.

- **Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he or she became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.

DentalGuard General Limitations and Exclusions: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles may apply for some options. The plan does not pay for: oral hygiene services (except as covered under preventive services), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage.

Additional Information

For additional information about dental benefits, call Guardian Member Services at 1-888-618-2016.

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered by This Plan

A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

- (a) he or she receives services or supplies from a dentist that is under contract with DentalGuard Preferred Provider Organization network; and
- (b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the DentalGuard Preferred network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.

Discounts on Services Not Covered Due to Contractual Provisions

If a covered person receives dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of DentalGuard Preferred network, even if such services are not covered by the plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions, such as dental implants.

CERTIFICATE AMENDMENT

This Preferred Provider plan is amended so that if a covered person is injured because of a third party's wrongful act or negligence: Guardian will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to Guardian being subrogated to any recovery or right of recovery the covered person has

against that third party; (b) does not take any action which would prejudice Guardian's subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery; Guardian will be subrogated only to the extent of benefits paid by this plan because of that injury; and Guardian will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider: "Subrogation" means Guardian's right to recover any benefit payments made under this plan: because of an injury to a covered person caused by a third party's wrongful act or negligence; and which the covered person later recovers from the third party or the third party's insurer. "Third Party" means any person or organization other than Guardian, the employer or the covered person. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

REQUIRED DISCLOSURE STATEMENT For Group Plan No.: G -00417732-HC

This section is a short summary of the benefits this Plan provides. These benefits, including any exclusions and limitations, are fully explained in the HSBP Plan Documents. Please contact the Plan Benefits Office for more details. This Plan provides the following health insurance benefits: Dental Expense Insurance (defined as Dental Insurance by the New York State Insurance Department). This Plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

Notice: The above statements are not part of the group policy. The group policy alone determines the rights and duties of: (a) the employer to whom this plan is issued; (b) the policyholder (if other than such employer); (c) Guardian; and (d) any person covered by this plan.

DENTAL BENEFIT (SUPPLEMENTAL)

(This Benefit is insured through HSBP)

Dental Guard Preferred

If the employee or eligible dependent is enrolled in the DentalGuard Preferred, this supplement will pay an additional 20% of the amount reimbursed by the dental carrier for covered services. This 20% supplement will be calculated based on the total reimbursements received under the Dental Plan during the benefit year. If the employee or eligible dependents are enrolled in a separate non-HSBP PPO plan, this supplement will pay 20% of the amount reimbursed by their dental carrier for covered charges. The maximum supplement per person per benefit year is 20% of \$5,000 in reimbursements, or \$1,000 per person per benefit year. In no way will the reimbursements be more than what was paid out of pocket.

Managed DentalGuard

If the employee or eligible dependent is enrolled in the Managed DentalGuard, this supplement will pay 20% of what the employee has paid in connection with receipt of covered Managed DentalGuard. With your claim form, you must submit an itemized statement of covered charges from your primary care dentist with the exact date(s), diagnosis and procedure codes for which services were rendered. Only services that are covered by your dental carrier will be reimbursed by the Plan. Scanned copies of your receipts for eligible dental expenses must be submitted to the Benefits Plan Office with the appropriate claim form. The maximum supplement per person per benefit year is 20% of \$5,000 in reimbursements, or \$1,000 per person per benefit year.

The Managed DentalGuard or DentalGuard Preferred reimbursements in combination cannot exceed the maximum supplement per person per benefit year of \$1,000.

SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional details, call the Benefits Office and ask for the HSBP Plan Documents.

DISABILITY BENEFITS - SUPPLEMENTAL SHORT TERM

(Self-Insured by the HSBP)

HHC Hospitals, Cambridge Health Alliance, Westchester Medical Center, LA County Hospitals,
and CIR and HSBP Staff Employees

Introduction

The Plan provides you with income during a period of disability due to a non-occupational accident or illness.

Supplemental Short-Term Disability Benefits are available for the employee only. The employee's spouse and other dependents are not eligible for benefits. If you become disabled while eligible for benefits under the Plan, Supplemental Short-Term Disability Benefits begin on the (8th) eighth day of a non-occupational disability. Benefits are payable for a maximum of 26 weeks during any one period of disability or until you are no longer disabled or no longer deemed disabled (i.e., the medical information does not substantiate the claim), if earlier.

Under this Plan, the maximum benefit payable is 70% of your weekly salary up to a maximum of \$875 per week. Your payment may come from different sources depending on the state in which you are employed as discussed later in this section and can include a statutory benefit as well as a Supplemental Short-Term Disability Benefit. The Supplemental Short-Term Disability Benefit payable by the Plan is the benefit amount above any statutory benefit provided by the state in which you are employed (if applicable) up to the maximum of \$875 per week.

Definition of Disability

"Disabled" means you are unable to work as a result of accidental bodily injuries, sickness, or pregnancy and are thereby prevented from performing the duties of your occupation and you are under the care of a legally licensed provider as defined by the State in which you work.

Duration of Benefits

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks. Payment of Weekly Benefits ends on the **earlier** of:

1. The date on which you are no longer disabled; or
2. After 26 weeks of disability benefits have been paid

If your Disability extends beyond twenty six weeks you may be eligible for Long Term Disability.

Partial Disability

Partial Disability, as defined by the Plan as any period during which you are able to perform any work for remuneration, is not covered under this plan. Benefits will only be paid for periods during which you meet the definition "disability."

Reduction of Benefits

If you receive other income while receiving Short-Term Disability Benefits, the Short-Term Disability Benefits you would otherwise receive will be reduced by any such other income. Such other income may be:

- New York or California state-mandated disability benefits;
- No-Fault wage replacement;
- Other statutory benefits; or
- Any amounts you receive for paid time off from your employer.

Exclusions

No benefits will be paid with respect to:

- Disabilities for work-related illnesses or accidents covered by Workers' Compensation or any other similar state or federal law;
- Any period during which you perform any work for remuneration or profit; or
- Any claim that is not filed within 60 days of the start of the first date of the disability, unless circumstances prevent you from filing the claim in a timely manner, in which case the claim must be filed within 12 weeks from the onset of disability.

Benefit for Employees of Northern California Employees

Your Supplemental Short-Term Disability Benefits are equal to 70% of your weekly salary up to a maximum of \$875 per week less any statutory benefits you receive (such as No-Fault wage replacement). Benefits will be payable by this Plan on a bi-weekly basis during the continuation period for which you are disabled. Benefits begin on the 60th day of disability. No benefits will be paid prior to the 60th day of disability, nor for more than 26 weeks.

Please note that sick leave benefits may be payable by the Hospital in which you work. If you receive payment for sick leave, any balance remaining after the payment for sick leave is made will be payable by this Plan under the Supplemental Short-Term Disability Benefits up to a maximum of \$875 per week.

In order to file a claim form for Supplemental Short-Term Disability benefits, obtain a claim form from the Benefits Plan Office and submit it to the Plan Office within 60 days of the start of your disability. A disability claim is a claim for benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant's disability. You must be under the care of a legally licensed physician, dentist, psychologist, podiatrist, nurse-midwife or chiropractor for your claim to be considered. This provider must, when requested by the Fund, certify the following: the scope of, the probable duration of, and all medical facts, to the best of his or her knowledge, about your disability. The Benefits Plan Office will evaluate your claim and determine if benefits are payable and reserves the right to have a physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.

The Benefits Plan Office will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, The Benefits Plan Office notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Benefits Plan Office receives your response to the request. If the Benefits Plan Office approves your claim, the decision will contain information sufficient to reasonably inform you of that decision. If a claim for Disability Benefits is denied, you have the right to appeal as follows:

- For Benefits payable under California SDI, you should follow the instructions on the denial from the State in order to appeal the denial.
- For appeals that pertain to the Supplemental Short-Term Disability benefits, please refer to the Plan's claims and appeals procedures that are contained in the section entitled, "Claim Review and Claim Procedure".

DISABILITY - LONG TERM Group # 348692

(This Benefit is insured through Guardian)

The following provides a quick guide to some of the Long Term Disability plan features which people want to know about most often. It's not a complete description of your Long Term Disability plan, but a summary:

Elimination Period (Waiting Period)

For disability due to injury or illness the waiting period is 180 days. Note that Supplemental Short Term Disability may cover the first 26 weeks after the onset of illness or of an accident.

Gross Monthly Benefit

70% of your prior monthly earnings, rounded to the nearest \$1.00, if not already a multiple thereof, limited to a maximum of \$3,500.00. **Note:** Guardian integrates your gross monthly benefit with certain other types of income you may receive. Read all of the terms of this plan to see what income Guardian integrates with, and how.

Maximum Payment Period

For a disability starting before the employee reaches age 60, the maximum payment period will last until the Social Security Normal Retirement Age. If the disability period starts when or after the employee reaches age 60, long term disability payments will continue based on a table. For example, if the long term disability begins at age 60, the maximum period will be 5 years. Should the long term disability begin at age 69, the maximum period will be 1 year.

Claim Provisions - Filing a Claim for Benefits

You must send the Benefits Office written notice of an injury or sickness for which you intend to file a long term disability claim within 30 days of the injury or start of the sickness for which a claim is being made. This notice should include your name and Social Security number and the plan number. You will be furnished with claim forms for filing proof of disability within 15 days of Guardian's receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to the Benefits Office within a reasonable period of time.

If you are not furnished with the forms within the time stated, Guardian will accept a written description of the injury or sickness that is the basis for the claim in place of Guardian's form. You must detail the nature and extent of the disability for which the claim is being made. If it is necessary to determine liability, as part of proof of loss, Guardian may require:

- (a) certification of the extent and nature of your disability from all doctors who have treated you for the cause of your disability;
- (b) certification of income from any other sources of income to which you may be entitled which may affect Guardian's benefit payments;
- (c) satisfactory evidence that you have applied for all benefits and payments from other income sources to which you may be entitled; and
- (d) proof of any income from other sources that you have received. Guardian may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not obtained can result in suspension or delay of long term disability benefit payments until such information or authorization is received by Guardian.

Time Limit for the Filing of a Claim

Any claim not filed within a reasonable period of time following the end of the elimination period will be denied and no long term disability benefits will be payable unless Guardian receives written proof that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year

retroactively from the date the claim is filed.

Continued Proof of Disability

Additional proof will be required. Written proof of your continued disability and doctor's care must be provided to Guardian within 30 days of each date Guardian makes such request.

Application for Other Income Required

You must apply for any disability or retirement benefits with which Guardian integrates and which Guardian feels you may be entitled to receive. If such benefits are denied, Guardian requires you to apply for them again. You are required to continue to appeal all denials until: (a) you receive written notification from Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If Guardian feels that you are entitled to any of the benefits noted above, Guardian will: (a) assume you are receiving such benefits; and (b) integrate the gross monthly benefit with the estimated amount of such benefits payable to you and any applicable dependents on behalf of your disability. But Guardian does not do this if you sign Guardian's agreement concerning benefits under which you promise: (a) to apply for any benefits Guardian integrates with; and (b) at Guardian's request, to reapply for such benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits. This paragraph does not apply to: (i) disability benefits from any compulsory benefit act or law; (ii) retirement benefits or retirement plan disability benefits under any other government plan which you receive as a result of your disability; and (iii) benefits from a Workers' Compensation law, an occupational disease law, or any other act or law of like intent. If Guardian estimates them, they adjust your net monthly payments when they receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals Guardian requires. In the case of (b), if such adjustment shows Guardian underpaid you, they will pay you the full amount of the underpayment in a lump sum.

Computing Your Net Monthly Benefit from This Plan

Your net monthly benefit under this plan is your gross monthly benefit, as determined on your initial date of disability, integrated with any other income with which this plan integrates that you receive or are entitled to receive. To compute your net monthly benefit under this plan: (a) determine your gross monthly benefit as shown above; and (b) from the gross monthly benefit, subtract the sum of all of the income with which Guardian integrates that you receive or are entitled to receive. The result is your net monthly benefit.

Your net monthly payment under this plan is your net monthly benefit determined above, reduced by 50% of any current monthly earnings you earn while disabled. If, during any month for which this plan pays benefits, the sum of the following: (a) your net monthly payment, as figured above; (b) the total amount of all other income with which this plan integrates that you receive or are entitled to receive; and (c) the amount of your current monthly earnings; is greater than the amount of your indexed prior monthly earnings, your net monthly payment for that month will be further reduced by that portion in excess of 100% of your indexed prior monthly earnings. This will not apply during any period of time that you are an employee in a Guardian rehabilitation program, as described in this plan, and have signed a valid rehabilitation agreement with Guardian.

Waiver of Premium

Guardian waives all premiums for your long term disability income insurance which fall due while you are entitled to receive a net monthly payment from this plan.

Rehabilitation Benefits under This Plan

If you are disabled under this plan and meet selection criteria as established by Guardian, you may be selected to enter into a rehabilitation agreement with Guardian. This agreement starts when: (a) Guardian informs you in writing that you have been accepted into the rehabilitation program; and (b) you agree in writing to participate in the rehabilitation program. You may be chosen for this program anytime you are disabled according to the terms of this plan. This includes during this plan's elimination period. The exact terms of the rehabilitation agreement may be different for each employee, but all agreements will set forth a plan designed to return you to gainful employment. Gainful employment is employment that is appropriate to your disability, skills, experience and prior monthly earnings.

If you are chosen for a rehabilitation agreement, you will be entitled to an enhanced benefit based on 110% of the net monthly payment to which you would have been entitled had you not entered into the rehabilitation agreement. If you are chosen for such an agreement with Guardian, you will continue to be subject to all the terms of this plan. The enhanced benefit will start on the later of: (a) the effective date shown on the rehabilitation agreement; or (b) the date you complete the elimination period. Your eligibility for the enhanced benefit will extend until the earliest of: (a) the date you are no longer disabled under this plan; (b) the date you earn or are able to earn at a rate of at least 80% of your indexed prior monthly earnings; (c) the date you die; (d) the end of this plan's maximum payment period; (e) the date you violate any of the terms of the rehabilitation agreement; (f) the date you elect to end the rehabilitation program; or (g) the date the rehabilitation agreement expires.

If you end a rehabilitation agreement on a basis that is not agreeable to Guardian, you may be required to repay any benefits paid that are in excess of what this plan would have paid had you not participated in the rehabilitation agreement. There are additional advantages available to an employee who participates in a rehabilitation agreement as described above. For more information on these incentives and how you may become eligible to receive them, contact a Guardian rehabilitation specialist.

Special Limitations Mental or Emotional Conditions, Alcohol Abuse and Drug Abuse

If you are disabled, as defined by this plan, by a mental or emotional condition, alcohol abuse or drug abuse, Guardian limits this plan's benefits. For the long term disability income coverage of this plan, a mental or emotional condition will include, but is not limited to, any of the following: bipolar affective disorder (manic depressive syndrome), schizophrenia, delusional (paranoid) disorders, psychotic disorders, depressive disorders, anxiety disorders, somatoform disorders (psychosomatic illness), eating disorders, mental illness.

For each disability due to a mental or emotional condition, alcohol or drug abuse, Guardian's payments stop at the earliest of: (a) the date during any one period of disability that you have received 60 net monthly payments; (b) the end of the maximum payment period; or (c) the date disability ends. Also, payments will be limited to a total of 60 months in your lifetime for all disabilities contributed to, or caused by, any and all of the conditions shown above. But, if at the end of benefit payments, you are being treated for the cause of your disability as an inpatient in a qualified institution for at least 14 consecutive days, Guardian extends the payments. Guardian extends them until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the maximum payment period; or (c) the date disability ends. By "qualified institution," Guardian means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your disability.

Pre-Existing Conditions

A pre-existing condition is a sickness or injury, including all related conditions and complications, for which, in the three months before your insurance under this plan starts, you: (a) receive advice or treatment from a doctor; take prescribed drugs; or receive other medical care or

treatment, including consultation with a doctor; or (b) exhibit symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. A pregnancy which exists on the date your insurance under this plan starts is also a pre-existing condition. Guardian does not cover disability caused by such a condition until the later of: (i) the day following the date you are insured under this plan for at least 12 consecutive months; and (ii) the date benefit payments would otherwise start in the absence of this provision. Guardian does not cover any disability which begins before your insurance under this plan starts.

Converting Your Group Long Term Disability Income Insurance

Eligibility for Conversion

When your coverage under this group long term disability income plan ends, you may obtain a converted individual disability income policy, subject to the conditions below. You will be eligible for the converted individual disability income policy if you: (a) are not disabled under the terms of this plan; (b) have been covered under this plan (or a prior group disability income plan which this plan replaced) for at least 12 consecutive months immediately prior to the date your group coverage ends; (c) have successfully completed the residency program in which you were enrolled; and (d) apply to Guardian in writing within 45 days after the date on which your coverage under this plan ends.

By residency program, we mean a program of internship or residency in a medical specialty, accredited by the American Council for Graduate Medical Education. But you will not be eligible for a converted individual disability income policy if your group long term disability coverage ends because you: (a) fail to make a required contribution; (b) change to a class not eligible under this plan; (c) fail to complete a program of residency; (d) retire; or (e) because coverage ends for all persons or all persons in a class under this plan.

You do not have to provide evidence of good health to obtain the converted individual disability income policy, but you may be subject to other underwriting criteria. You must provide details concerning other disability income insurance in force or applied for, or for which you would become eligible under another plan within 45 days after the date that this group coverage ends. Guardian will not issue a converted individual disability income policy if such policy would result in your being over insured by our standards.

To Obtain a Converted Individual Disability Income Policy

You must apply to Guardian in writing and pay any required premium to obtain a converted individual disability income policy. You must do this within 45 days of the date on which your group long term disability coverage ends. If you fail to apply to us in writing and pay any required premium within 45 days of the date your group long term disability coverage ends, you are no longer eligible to obtain a converted individual disability income policy.

The Converted Individual Disability Income Policy

Your converted individual disability income policy, if issued, will be effective on the day your coverage under this group plan ends. The benefits, terms and conditions of the converted individual disability income policy will be those of the policy in use for such purpose in the state where you then live. These may be different from the benefits, terms and conditions of this group long term disability plan. The premium for the converted individual disability income policy will be that in effect for your age and class of risk on the date the policy is issued.

CERTIFICATE AMENDMENT

This Long Term Disability plan is amended so that if a covered person is injured because of a third party's wrongful act or negligence: we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to Guardian being subrogated to any recovery or right of recovery the covered person has against

that third party; (b) does not take any action which would prejudice our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery; we will be subrogated only to the extent of benefits paid by this plan because of that injury; and we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider: "Subrogation" means our right to recover any benefit payments made under this plan: because of an injury to a covered person caused by a third party's wrongful act or negligence; and which the covered person later recovers from the third party or the third party's insurer. "Third Party" means any person or organization other than Guardian, the employer or the covered person. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G –00348692

This section is a short summary of the benefits this Plan provides. These benefits, including any exclusions and limitations, are fully explained in the HSBP Plan Documents. Please contact the Benefits Plan Office for more details. This plan provides the following health insurance benefits: Long Term Disability Income Insurance (defined as Disability Income Insurance by the New York State Insurance Department). This plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department. **Notice:** The above statements are not part of the group policy. The group policy alone determines the rights and duties of: (a) the employer to whom this plan is issued; (b) the policyholder (if other than such employer); (c) Guardian; and (d) any person covered by this plan.

SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional details, call the Benefits Office and ask for the HSBP Plan Documents.

CONTINUATION OF BENEFITS WHILE YOU ARE DISABLED

(This Benefit is insured through HSBP)

Continuation of Benefits

If you go off payroll because of disability, you continue to be eligible for up to twelve (12) months coverage for all HSBP benefits if you are collecting disability benefits from the Plan. In addition, the Plan will reimburse you up to \$1,500 toward the cost of continuing your basic health coverage for twelve months on a direct payment basis (paid receipts required).

HEARING AID BENEFIT

(This Benefit is insured through HSBP/EPIC Hearing)

Eligibility: HHC Hospitals, Westchester Medical Center and CIR and HSBP employers, including eligible dependents.

Maximum coverage allowed: A lifetime maximum of \$5,000 per ear to cover the cost of a hearing aid.

HSBP will cover you and/or your eligible dependents when services are provided by EPIC Hearing Health Care or will reimburse you a lifetime maximum of \$5,000 per ear.

Using an in-network EPIC Hearing Provider

Contact EPIC toll free at [866-956-5400](tel:866-956-5400) and identify yourself as a **CIR- House Benefits Plan Member**. EPIC personnel will register you, and obtain your CIR Member ID* to confirm eligibility with the Benefits Plan Office. Once eligibility is confirmed, a referral will be issued to an audiologist closest to your home or work. EPIC will notify the audiologist of the patient referral and mail you a copy for your records. The audiologist will evaluate the hearing and submit their audiometric results with hearing aid prescription to EPIC. You will receive a plan booklet outlining all plan services and pricing. When you visit your EPIC provider, all benefits will be coordinated for you, and you will only need to pay for services that exceed the \$5,000 per ear lifetime allowance. You will **not** need to file a claim for reimbursement.

You and/or your eligible dependents are entitled to a 45 day trial period. Once you accept the device at the completion of the trial period; EPIC will submit a claim to the Benefits Plan Office for payment.

EPIC offers all makes and models from all manufacturers at 30-60% off MSRP; with prices starting as low as \$495. And can we also add our call center hours? (Contact the EPIC Hearing Service Plan toll free Monday - Friday 8:00 a.m. to 8:00 p.m. CST.)

*Please note: You may find your CIR Member ID # on your optical card from Davis Vision. If you do not have your card or not eligible to receive the card, please contact the Benefits Office M-F 9AM-6PM (p) 212-356-8180.

Filing an out-of-network claim for reimbursement

A claim form may be obtained online at www.cirseiu.org/hsbp

- Entire Claim form must be completed in full by participant, patient or parent, if minor.
 - A separate claim form must be submitted per patient.
 - The need for a hearing aid must be approved by a certified audiologist and a letter from the audiologist a letter from the audiologist must be submitted with the original bill.
 - The bill must state the provider's name, address and phone number, patient's name and address, services rendered, date of service and amount of purchase.
 - Claims must be submitted to our within one year from date of purchase. The Plan reserves the right to request original receipts.
-

IDENTITY THEFT MONITORING AND PROTECTION BENEFIT

(This Benefit is insured through Identity Theft Solutions of America)

As of January 1, 2014 all HHC, WMC, CIR and HSBP staff participants are eligible for a free subscription to Identity Theft Solutions of America while on contributing payroll. Identity Theft Solutions of America will provide online global monitoring of the following elements:

- Email addresses
- Bank account numbers
- Medical ID numbers
- Credit and debit cards
- Phone numbers

You will also receive three-bureau credit report (Transunion, Experian, Equifax), Credit scores from all 3 bureaus, 24/7 credit monitoring with activity alerts from all 3 bureaus, Social security number trace and complete restoration. During the complete restoration process you will be assigned a certified ID Theft Risk Management Specialist, who will completely restore your identity in the event a theft occurs.

Spouses, registered domestic partners, dependents and affiliates can register for a discounted self-pay rate of \$6.50 per person per month dollars per person.

To register for this free benefit call IDTSOA M-F 888-588-2094 and provide your name and CIR member ID (as found on your Davis Vision optical card) to receive your FREE Promo code and login instructions.

LA COUNTY GAP INSURANCE

(This Benefit is insured through HSBP)

House staff physicians who are employed by the County of Los Angeles who experience a 2 month waiting period for LA County health insurance are eligible for this benefit.

This benefit reimburses up to a maximum of \$500 for the purchase of COBRA or a form of GAP coverage to cover yourself and/or your family during this 60 day waiting period.

To submit for reimbursement you must complete:

- An entire claim form, and
- You must attach a copy of the COBRA notice and proof of payment. e.g. canceled check, electronic payment, or
- a copy of the receipt for purchasing the policy.
- All claims must be submitted to the House Staff Benefits Plan Office within one year from the end of the 2 month waiting period that was covered. Claims submitted after one year will be denied.

LIFE TERM INSURANCE Group # 348692

(This Benefit is insured through Guardian Life Insurance)

A death benefit of \$150,000 will be paid to any beneficiary you name, if you die from any cause while you are covered under this Plan. You may change your beneficiary whenever you wish. If you fail to name a beneficiary, this benefit will be paid to your estate.

Your Term Life Insurance is assignable only as a gift assignment.

You must be at work actively on a full time basis to be eligible for any changes in the terms of this benefit.

Insurance During Total Disability

If you are eligible for benefits under this Plan and you become disabled before you reach age 60, your Term Life Insurance may be continued at no cost to you while you remain totally disabled. This benefit is also called the Extended Life Benefit with Waiver of Premium. You must furnish proof of total disability within one year of the date total disability starts, and as required thereafter. If you die during the first year of total disability, your death benefit will be paid to your beneficiary even if you had not yet furnished proof of the disability. For the purpose of this section only, you will be considered totally disabled only if:

- You are not engaged in any gainful occupation, and
- You are completely unable, due to sickness or injury or both, to engage in any gainful occupation for which you are reasonably fit, by education, training or experience.
- You are receiving regular doctor's care appropriate to the cause of the disability; unless you have reached your maximum point of recovery yet are still disabled under the terms of the Plan.
- You remain totally disabled for nine consecutive months. However, you may apply for this benefit immediately upon the onset of disability.

In the event that you receive the Extended Life Benefit with Waiver of Premium nine months after you become disabled, in order for you to maintain your Dependent Life Insurance coverage, you must convert your spouse's policy to an individual permanent or term policy.

Accelerated Life Benefit

IMPORTANT NOTICE: Use of the benefit provided in this section may have tax implications and may affect government benefits or creditors. You should consult with your tax or financial advisor before applying for this benefit.

NOTE: The amount of group term insurance is permanently reduced by the amount of the accelerated benefit paid to you.

An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die. If you have a medical condition that is expected to result in your death within 6 months, you may apply for the Accelerated Life Benefit. The minimum amount of the Accelerated Life Benefit for which you can apply is \$50,000. The maximum amount of the Accelerated Life Benefit for which you can apply is \$75,000.

Guardian will not pay an Accelerated Life Benefit to you if you are required by law to use the payment to meet the claims of creditors whether or not you are in bankruptcy; or are required by court order to pay all or part of the benefit to another person; or are required by a government agency to use the benefit to apply for, to receive or to maintain a governmental benefit or

entitlement; or lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before Guardian pays such benefit to you.

Burial Benefit: At its option, Guardian Life Insurance may pay up to \$500 of the life insurance benefit to any person who appears to have incurred an expense in connection with your burial. Guardian's liability will be discharged to the extent of the amount paid.

Beneficiary Designation

You may change your beneficiary at any time by filing a written notice of the change with the Plan Office.

If you designate more than one beneficiary and fail to specify each beneficiary's share, each beneficiary will receive equal shares. If your beneficiary dies before you do, his or her share will be shared equally by any beneficiaries that survive you, unless you indicate otherwise. If all your beneficiaries die before you do, or your life insurance benefit amount cannot otherwise be disposed of, the amount will be payable to your estate unless you made a gift assignment.

Conversion to an Individual Policy

During the first 31 days following:

- the termination of your employment, or
- the group policy providing your Group Term Life Insurance ends, or
- the amount of your insurance is reduced by amendment,

You may convert your Group Term Life Insurance to one of a number of Guardian individual life insurance policies up to the amount of the coverage you lost. You must apply in writing for a conversion policy and pay the first premium within 31 days after your insurance ends or is reduced. You will not have to furnish evidence of good health. The policy will be effective at the end of the 31-day period, and the premiums will be based on current individual policy premium rates. If you die during the 31-day period, your death benefit will be paid whether or not you have applied for an individual policy.

By law, you are responsible for the value of your life insurance over \$50,000. You will be notified of the amount by your employer.

SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional details, call the Benefits Office and ask for the HSBP Plan Documents.

ANCILLARY DEATH BENEFIT

(This Benefit is insured through HSBP)

The purpose of this benefit is to assist in the payment for transporting the remains of a deceased employee or deceased eligible dependent to the place of burial. The benefit will cover up to a maximum of \$5,000 for transportation of the remains of a deceased employee to the place of burial where the place of burial is more than 200 miles from New York City.

At the time notification of the death is made to the Benefits Plan Office, the Benefits Representative will assist the caller with this benefit.

LIFE TERM INSURANCE FOR YOUR DEPENDENT SPOUSE OR REGISTERED DOMESTIC PARTNER

(This Benefit is insured through Guardian Life Insurance)

A death benefit of \$20,000 will be paid to you if your legal spouse or registered domestic partner dies from any cause while covered under this Plan.

Conversion to an Individual Policy

During the first 31 days following:

- the Term Life Insurance for your Dependent Spouse ends, or
- the amount of the Term Life Insurance for your Dependent Spouse is reduced by amendment, your spouse may convert such life insurance to one of a number of Guardian individual life insurance policies up to the amount of coverage lost without the need to furnish evidence of good health. Your spouse must apply in writing for a conversion policy and pay the first premium within 31 days after his/her insurance ends or is reduced. The policy will be effective at the end of the 31-day period, and the premiums will be based on current individual policy premium rates. If your spouse dies during the 31-day period, this death benefit will be paid whether or not your spouse has applied for an individual policy.

In the event that you, the employee, become totally and permanently disabled and you apply for and receive the Extended Life Benefit with Waiver of Premium, life insurance for your spouse will terminate. In order to maintain your spouse's coverage, you must convert the coverage to an individual policy.

If your dependent is confined for medical care or treatment either in an institution or at home on the date this dependent life insurance would otherwise go in effect, or on the date any adjustment to the benefit amount would become effective, then your dependent's insurance will be deferred until his/her final release from medical confinement.

SPD is a quick reference guide to your benefits through the House Staff Benefits Plan. For additional detail, call the Benefits Office and ask for the HSBP Plan Documents.

MAJOR MEDICAL BENEFIT (supplemental)

(This Benefit is insured through HSBP)

The Plan will supplement reimbursements you have received from your primary major medical carrier (under your hospital's base plan). You must attach the Explanation of Benefits (EOB) received from your primary carrier. Health insurance deductibles are **not** reimbursable under this benefit.

This supplement will pay an additional 20% of the amount reimbursed in connection with benefits provided by your primary major medical carrier. No benefits will be provided for mental, psychoneurotic and personality disorders. This 20% supplement will be calculated based on the total reimbursements received under the base plan during the benefit year. The maximum supplement per person per benefit year is 20% of \$5,000 in reimbursements or \$1,000 per person per benefit year. In no way will reimbursements be more than what was paid out of pocket.

For Example: Your dependent requires a surgery for which the surgeon charges \$8,000.00. The usual and customary charge for this surgery is \$8,000.00, and your primary carrier will pay 80% of the charges, or \$6,400.00. Since your dependent has not used the Supplemental Major Medical Benefit in this plan year, you will be paid 20% of the amount reimbursed by the primary carrier up to the annual limit of \$1,000.00. Since 20% of \$6,400.00 is \$1,280.00, you will be paid \$1,000.00 or the annual Supplemental Major Medical Benefit maximum.

Under the Supplemental Major Medical Benefit, you may also receive reimbursement for co-pay amounts for office visits, out-patient diagnostic tests (x-rays, lab tests, etc.), emergency room care and hospital admissions. These co-pay amounts will be reimbursed up to 100% and will be a part of the Supplemental Major Medical Benefit with the annual benefit year maximum of \$1,000.00. The following is the procedure for obtaining a reimbursement for a co-pay from the Supplemental Major Medical Benefit.

For example: Your primary major medical carrier is Guardian. Your co-pay for an office visit is \$15.00. You obtain a receipt for the office visit for the \$15.00 co-pay because you cannot be reimbursed under the Supplemental Major Medical Benefit without one. You submit the receipt and EOB along with a claim form. Assuming you have not yet met your \$1,000.00 Benefit Year maximum, you will be reimbursed \$15.00.

Smoking Cessation Benefit

Smoking Cessation expenses are covered under Major Medical Benefit reimbursement and subject to the \$1,000 per person per benefit year maximum. Acceptable programs include Smoke Enders, and programs sponsored by the New York Lung Association. The Smoking Cessation Benefit can also be used to reimburse you for nicotine patches or gum.

If you are unsure as to whether the service is being rendered by an "Eligible Provider," please contact the Benefits Plan Office.

A "Benefit Year" is a period of twelve consecutive months beginning July 1 and running through the following June 30.

MENTAL HEALTH OUTPATIENT BENEFIT

(This Benefit is insured through HSBP)

The eligible expenses are charges incurred for the services of an eligible provider in connection with diagnosis and treatment of mental, psychoneurotic and personality disorders. These services must be rendered on an outpatient basis.

During the benefit year, out-patient psychiatric benefits will be reimbursed at 80% of the reasonable and customary provider charge not to exceed \$200 per office visit (for example: the maximum a member may receive is \$160; 80% of a \$200 office visit is \$160). In no instance will the HSBP reimburse the member for more than what the member is responsible for in copayments or coinsurance charges. In addition, in no instance will the maximum benefit per individual per Benefit Year exceed \$5,000. A "Benefit Year" is a period of twelve consecutive months beginning July 1 and running through the following June 30. Your eligible provider must complete your claim(s) with the exact date(s), diagnosis and procedure codes for which services were rendered.

Eligible Providers

Eligible providers must be certified and licensed. Their degrees can be any one of the following: M.D., Ph.D., EdD., PsyD. (Doctor of Psychology), MSW (Master of Social Work), CSW (Certified Social Worker) or Psychiatric Nurse Practitioner (RN together with a master's, post-master's or doctorate from an accredited program). If you are unsure as to whether an "Eligible Provider" is rendering the service, please contact the Benefits Plan Office.

Exclusions

This benefit does not cover expenses due to:

- Services rendered by an eligible provider during a hospital confinement resulting in a room and board charge.
- Sickness covered under Workers' Compensation or similar laws.
- Services (a) furnished by or for the U.S. Government, or (b) furnished by or for any other government unless payment is legally required or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.
- Anything not ordered by an eligible provider, or not necessary for medical care; the portion of a charge for a service in excess of the reasonable and customary charge (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience).
- Covered services rendered by yourself, your spouse, or, in New York State only, your domestic partner or a child, brother, sister, or parent of yourself, your spouse.
- Services received as a result of an act of war occurring while covered.
- Care that is not medically necessary.

If any information is missing from the claim form, it must be furnished to the HSBP before the claim can be adjudicated.

NEWBORN BENEFITS

(This Benefit is insured through HSBP)

These benefits are provided for each delivery while you, your spouse or your domestic partner is covered by this Plan.

The Benefit

The Plan reimburses up to \$1,000.00 for Newborn Expenses, Well Baby Care, Circumcision and Childbirth Education. You may divide this sum among one to four benefits or use the entire sum for one of the benefits.

Basic Maternity Coverage

The basic health insurance provided by the hospital through which you are employed will include coverage for maternity-related expenses. Your basic coverage will also cover routine nursery charges except for the deductible, if your basic coverage has a deductible.

Newborn Expenses

The HSBP provides coverage for all unreimbursed medical expenses in connection with a newborn for the first 60 days of the child's life (including children who are adopted). You are to submit your unreimbursed expenses the same as you would any other medical expenses. However, if the expense is one that would ordinarily be covered by your basic coverage, you must include a rejection form from your basic coverage insurance carrier.

Well Baby Care

This self-insured benefit pays for a pediatrician's in-hospital newborn baby care. You must submit an original bill or an Explanation of Benefits (EOB) from your basic insurance carrier showing all or part of the pediatrician's in-hospital newborn baby care was not covered.

Circumcision

The Plan will pay for circumcision by a physician or a certified mohel up to 24 months old.

Childbirth Education Benefit

This benefit enables you to get information and education about childbirth by providing you with up to 6 group sessions or 3-4 private sessions conducted by practitioners who have been accredited with one of the agencies listed:

- ICEA- International Childbirth Education Association
- American Academy of Husband Coached Childbirth Education Association
- ASPO- National Organization for the Lamaze Method
- Childbirth Education Specialist, Inc.

OBSTETRICAL BENEFIT (supplemental)

(This Benefit is insured through HSBP)

The Plan will provide supplemental payment for basic obstetrical benefits reimbursed by your primary medical coverage. The supplemental payment for obstetrical benefits is up to \$1,000 per delivery and is not subject to any deductible. You must attach an Explanation of Benefits from your primary carrier as well as a paid receipt from the provider service. The paid receipt must include the dates of service, the services rendered and the charge for each service.

Breast pumps, lactation classes and supplies relating to the delivery are payable at 100% under this benefit. **Note that private hospital rooms are NOT covered under this or any other benefits in this Plan.**

Claims must be submitted within one year of the delivery and you must be on payroll when you incur the service charges.

Claims for breast pump and accessories* may be purchased before or after delivery, however claims will not be eligible for reimbursement until such time that the newborn is added to the House Staff Benefits Plan. Claims must be submitted within one year of the date of purchase (**not date of delivery**) and the member must be on payroll when the service charges are incurred AND the time of delivery.

Eligible breast pump accessories include bottles, breastmilk storage bags and containers, breast shields, pump bags, valves, membranes, nursing bras and bustiers. Diapers, maternity belts, shapewear or other clothing will **NOT be reimbursed.*

QI/PATIENT SAFETY EDUCATIONAL BENEFITS FOR LA RESIDENTS

(These 3 Benefits are provided through HSBP in 2014)
THESE BENEFITS COVER ONLY LA COUNTY EMPLOYEES

HSBP is committed to providing resident physicians the tools to deliver the best patient care and will be providing the following three QI educational benefits

CONFERENCES

QI/PATIENT SAFETY

The Plan will reimburse up to \$25,000 to fund a one day QI/Patient Safety Conference in Los Angeles, CA. All HSBP LA participants will be invited to attend and participate with no out-of-pocket costs to attend the lectures. The appropriated monies will cover reasonable expenses including but not limited to: expenses for venue, audio visual materials, food and expenses related to speaker's travel or honorarium.

WOMEN IN MEDICINE

HSBP will provide up to \$25,000 to sponsor educational and training programs on "leadership development for women in medicine" including but not limited to: lecture series or one-day conference training women for leadership development in medicine. All HSBP LA participants in the relevant geographic area will be invited to the lecture series or educational conference and HSBP participants will have no out-of-pocket costs to attend the lectures or educational conference. The appropriated monies will cover reasonable expenses of each lecture or conference including but not limited to: expenses for venue, audio visual materials, food and expenses related to speaker's travel or honorarium.

QI SCHOLARSHIP BENEFIT

This benefit will cover participant(s) to attend a Quality Initiatives and Patient Safety sponsored program during 2014. The participant(s) from LAC+USC and/or Harbor-UCLA will be eligible to receive up to \$3,000 in funding to cover the expenses related to registration and travel to attend this event. The participant that attends the conference is responsible for receiving time off (vacation or education leave time) to attend the conference. This benefit will not cover any shift coverage to attend this event. The benefit will apply to an HSBP LA participant that will continue in the LA County bargaining unit for the following academic year. Applications will be reviewed by the CIR Southern California Regional Vice-President and Chairperson of HSBP.

Conference participants agree to present what they learned at the conference to their LA colleagues (for example, at a CIR meeting open to all bargaining unit members, grand rounds, departmental presentations or intern orientation).

QI WORKSITE SPECIFIC CURRICULUM

HSBP will provide up to \$30,000.00 to be divided equally between Harbor-UCLA and LAC+USC Medical Centers to implement worksite specific curriculum, projects and/or training of HSBP participants on ACA principals including but not limited to: patient safety, quality and efficiency, prevention, community health and wellness, patient advocacy, EHR and cost savings.

QI/PATIENT SAFETY EDUCATIONAL BENEFITS

THESE BENEFITS COVERS ALL CONTRIBUTING EMPLOYERS OF THE HSBP

HSBP is committed to providing resident physicians the tools to deliver the best patient care and will be providing the following three QI educational benefits.

QI/PATIENT SAFETY CONFERENCE

The Plan will fund a series of QI/Patient Safety Learning Events and to disseminate QI/ Patient Safety resource information. All covered employees will be invited to attend the Events and be able to access resources created. There will be no registration fee for eligible covered employees to attend these events or to access QI/Patient Safety resource information. HSBP will partner with PEI to create the series of learning events and to disseminate resource information.

HSBP PATIENT SAFETY EDUCATION AND TRAINING SCHOLARSHIPS

HSBP will be providing scholarships for eligible covered employees to access approved Quality Initiatives and Patient Safety sponsored programs available in the US. Participants will be eligible to receive benefits of up to \$3,000 per residency year to cover the expenses related to registration, travel, and tuition. Covered employees accessing this benefit are responsible for receiving time off (vacation or education leave time) to attend or participate in these educational opportunities. Applications to participate in this benefit will be granted on an equitable basis based on completion of [HSBP QI Training & Education Application and Reimbursement](#) form and criteria developed by a Subcommittee of the HSBP Trustees. This application will include an explanation detailing how the applicant will present what they learned at the conference to their hospital colleagues. (for example, at grand rounds, departmental presentations, or intern orientation).

A list of recommended programs are listed below.

Agency for Healthcare Quality and Research (AHRQ) Annual Conference
American Association of Medical Colleges (AAMC) Integrating Quality Conference
American College of Medical Quality (ACMQ) Annual Meeting
Institute for Healthcare Improvement (IHI)
NPSF National Patient Safety Conference
Annual Quality and Safety Educators Academy (QSEA)
Telluride Patient Safety Roundtable
Association for Graduate Medical Education (ACGME) Annual Conference
National Association for Health Quality (NAHQ) Annual Educational Conference
National Quality Forum (NQF) Annual Conference

VISION BENEFIT

(This benefit is provided by Davis Vision – Client Code 2200)
 HHC Hospitals, Cambridge Health Alliance, Westchester Medical Center, and
 CIR and HSBP Staff Employees

In-Network Benefit

The Plan offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependents use your benefit in-network you will be entitled to:

- Free eye exam as of every July 1st
- Lenses every July 1st
- Frames every July 1st
- Contacts Lens Benefits (in lieu of eyeglasses) (Every July 1st)

Note: If you choose a frame that is NOT in the Davis Vision collection, you will be given a \$150 allowance toward any frame from the participating provider plus 20% off the balance.

Contacts

Collection Contacts and lens fitting covered in full
 or
 Non Collection Contacts 15% discount of balance, and lens fitting fee

Participating Providers

To locate a provider in the Davis Vision network, log on to the Open Enrollment section at davisvision.com and enter client code 2200. To use your benefit in-network, present your Davis Vision Member ID card or give the provider our client code (2200) and your first and last name.

Out-of-Network Benefit

You may receive services from an out-of-network provider, however, you will receive the greatest value when you go in-network. If you choose an out-of-network provider, you will receive a maximum of \$50 per year toward an eye exam and \$150 toward materials. You must file a claim with Davis Vision to be reimbursed. (This applies to eyeglasses or contact lenses).

Claims should be mailed to:

Vision Processing Unit
 PO Box 1525
 Latham, NY 11210

Lens Types and Coatings	Member Prices
Clear Plastic Lenses, all ranges of prescriptions and sizes (single vision, bifocal, trifocal)	Included
Oversized Lenses	Included
Tinting of Plastic Lenses	Included
Scratch Resistant Coating	Included
Polycarbonate Lenses*	Included
Ultraviolet Coating	Included
Intermediate Vision Lenses	Included
Standard Progressives	Included
Premium Progressives (Varilux [®] , etc.)	\$40
Plastic Photosensitive Lenses (Transitions [®])	\$65
Polarized Lenses	\$75
Standard Anti-Reflective (AR) Coating	\$35
Premium AR Coating	\$48
Ultra AR Coating	\$60
High-Index Lenses	\$55
Scratch Protection Plan (Single-vision Multifocal)	\$20 \$40

VISION BENEFIT

(This benefit is provided by Davis Vision)
THIS BENEFIT COVERS EMPLOYEES OF LA COUNTY ONLY

In-Network Benefit

The Plan offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependents use your benefit in-network you will be entitled to:

- Free eye exam every July 1
- Lenses every July 1 (See copay chart for lens options and copay amounts)
- Frames once every two plan years (every *other* July 1) as follows:
 - Any Fashion frame from the Davis Vision Collection (valued up to \$125) will be covered in full
 - A \$15 copayment will be applied for a Designer frame
 - A \$40 copayment will be applied for a Premier frame
- Contacts every July 1 (in lieu of eyeglasses)

Note: If you choose a frame that is NOT in the Davis Vision collection, you will be given a \$50 allowance toward any frame from the participating provider plus 20% off the balance.

Contacts

If you require a contact lens fitting, you will receive a 15% discount off the fitting exam when you visit an in-network provider. You will receive \$100 allowance toward any provider supplied contact lenses, plus 15% off the balance.

Participating Providers

To locate a provider in the Davis Vision network, log on to the Open Enrollment section at davisvision.com. To use your benefit in-network, present your Davis Vision Member ID card or give the provider your first and last name.

Out-of-Network Benefit

You may receive services from an out-of-network provider, however, you will receive the greatest value when you go in-network. If you choose an out-of-network provider, you will receive a maximum of \$40 per year toward an eye exam and \$60 toward materials. You must file a claim with Davis Vision to be reimbursed.

Claims should be mailed to:

Vision Processing Unit
PO Box 1525
Latham, NY 11210

Lens Types and Coatings	Copay
Clear Plastic Lenses, all ranges of prescriptions and sizes (single vision, bifocal, trifocal)	\$0
Oversized Lenses	\$0
Scratch Resistant Coating	\$0
Tinting of Plastic Lenses	\$15
Polycarbonate Lenses*	\$0-\$35
Ultraviolet Coating	\$15
Intermediate Vision Lenses	\$30
Standard Progressives	\$65
Premium Progressives (Varilux®, etc.)	\$105
Plastic Photosensitive Lenses (Transitions®)	\$70
Polarized Lenses	\$75
Standard Anti-Reflective (AR) Coating	\$40
Premium AR Coating	\$55
Ultra AR Coating	\$69
High-Index Lenses	\$60
Scratch Protection Plan (Single-vision Multifocal)	\$20 \$40

*Polycarbonate lenses covered in full for dependent children, monocular patients & patients with prescriptions 6.00 diopters or greater

Other Benefits

Davis Vision also provides discounts on laser vision correction and replacement contacts through LENS123©, a mail-order contact lens service. Visit davisvision.com for more information or contact Davis Vision at 1-877-923-2847.

Appeals

Appeals for vision benefits should be directed to Davis Vision. Your request for review must be made in writing within 180 days after you receive notice of denial. Call Davis Vision Quality Assurance at 1-888-343-3470 or address your complaint, grievance or appeal to:

Davis Vision Inc.

Attention: Quality Assurance/Patient Advocate Department

PO Box 791

Latham, NY 12210

If you are dissatisfied with the outcome of your appeal, you can file a Level 2 Appeal to the Trustees. Refer to the Claims and Appeals section of this booklet for more information.

PRESCRIPTION DRUG BENEFIT

WMC, COBRA, CIR and HSBP Staff Only

(This Benefit is insured through HSBP)

The Plan provides supplemental prescription drug benefits for you and your eligible dependents. Effective July 1, 2009, the benefit provides up to \$500 per benefit year per covered individual.

A benefit year is a period of twelve consecutive months beginning July 1 and running through the following June 30. Paid prescription receipts for eligible legend prescriptions should be submitted to the Benefits Plan Office with the appropriate claim form. Prescription drug expenses eligible for reimbursement are prescriptions which are:

- obtainable only by a physician's written prescription;
- dispensed by a licensed pharmacist; and
- approved by the United States Food and Drug Administration.

THERE IS A ONE-YEAR LIMITATION ON THE SUBMISSION OF CLAIMS FOR HSBP-INSURED BENEFITS.

PRESCRIPTION DRUG BENEFITS Supplemental

(HHC HOSPITALS ONLY)

PROVIDED THROUGH EXPRESS SCRIPTS INC. (ESI – Group JRGA)

This benefit is a supplemental RX coverage that should be used in conjunction with your employer's primary prescription plan. The Plan highly recommends the member enroll in the employer prescription plan for themselves and their family. Whenever possible use your primary prescription carrier prior to the supplemental debit card.

Employees will be mailed two cards per household and informational materials. You may use the cards immediately. Please note: Employees and their dependents may not be issued a card if a **completed** enrollment card was not presented to the benefits office.

Cards will be issued at **\$500 per eligible individual in the family**. Members can obtain discounts for prescription drugs at any one of **ESI's** participating providers nationwide. The card acts like a debit card. Cards are presented to the participating pharmacy for eligibility verification. Once eligibility is established, the cost of the prescription will be reduced by a **discounted** rate. Members will not have to pay any cash/payment upfront. When the balance on the card reaches zero, members can continue to use the cards to fill prescriptions at a discounted price. In the event the card does not have a sufficient balance to pay for the full prescription, the cost of the purchase will be applied to the card and the remaining balance will be the member's responsibility. **Members are highly encouraged to submit any out of pocket cost for reimbursement.**

It is important to note this card does not cover any over the counter drugs or medications. To determine the participating providers, you can logon and register at www.express-scripts.com or call the customer service phone number on the back of your card.

ESI's customer service representatives can also inform you of your card balance. Claim forms can be found at www.cirseiu.org. For additional savings you can use ESI's mail order program to get a ninety day supply for the cost of two copayments. For replacement of a lost card, please contact ESI @ **1-800-467-2006**. For reimbursement, please mail claim forms and receipts to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Prescription drug expenses eligible for reimbursement are prescriptions which are:

- obtainable only by a physician's written prescription;
- dispensed by a licensed pharmacist; and
- approved by the United States Food and Drug Administration.

**THERE IS A ONE-YEAR LIMITATION ON THE SUBMISSION OF CLAIMS FOR
HSBP-INSURED BENEFITS**

SUBSTANCE ABUSE COUNSELING AND TREATMENT BENEFIT

(This Benefit is insured through HSBP)

This benefit provides, in each Benefit Year, up to a total of 21 days for in-hospital detoxification and up to 28 days for in-patient rehabilitation. Benefits are payable after you or your dependents have exhausted basic plan benefits provided by you or your spouse's employer. Outpatient psychiatric coverage for substance abuse counseling is subject to the rules previously described for the Outpatient Psychiatric Benefit. In addition, the benefit will cover 80% of additional charges. However, the regular benefit plus the additional outpatient coverage for substance abuse counseling cannot exceed \$6,500 a year.

Benefits are also provided when certain services are required by the Committee for Physicians' Health of the Medical Society of the State of New York. Two types of care are covered:

- In cases of substance abuse: AFTERCARE will be reimbursed at 80% of expenses up to a maximum of \$400 per month for a maximum period of 24 months.
- In cases of substance abuse suspicion: expenses incurred from urinalysis monitoring will be reimbursed at 100% of expenses up to a maximum of \$400 per month for a maximum period of 24 months.

Please Note: Basic Plan benefits must be exhausted prior to coverage.

CLAIMS INFORMATION

Special claims rules may apply to certain dental and medical benefits. See the sections discussing those benefits.

How Medical and Dental Benefits Are Paid

To receive Plan benefits, you or your health care provider must submit a written proof of claim. In most instances, a completed claim form contains the necessary proof of claim, but in some instances, additional information or records may be required.

Generally, benefits payable on account of expenses for a Hospital or specialized health care facility will be paid directly to the institution providing the services. Likewise, benefits payable on account of expenses for surgery will be paid directly to the surgeon or anesthesiologist providing the services. When deductibles or coinsurance apply, you are responsible for paying your share of the charges. However, if at the time you submit your claim, you furnish evidence acceptable to the HSBP Office or its designee that you or your covered dependent paid some or all of those charges, you will be paid benefits up to the amount you initially paid for those services.

How to File a Claim

If you receive services from a member of the Guardian Managed DentalGuard, or if you receive Vision Benefit services from a member of the HSBP vision network, you do not have to submit a claim form. If you receive services otherwise, you must submit claims forms to the appropriate carrier or the HSBP Office. You may obtain forms and information from the HSBP Office. Call us at (212) 356-8180; e-mail us at benefits@cirseiu.org; or write to us at 520 Eighth Avenue, Suite 1200, New York, NY 10018.

Also, see the sections discussing the Supplemental Short-Term Disability Benefit and Long-Term Disability Benefit for important information regarding filing a claim for these benefits.

How to Complete a Claim Form

Complete the employee part of the claim form in full. Answer every question, even if the answer is “none” or “not applicable (N/A).”

The instructions on the claim form will tell you which documents or medical information is necessary to support the claim. Your Physician or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains all of the following information:

- a description of the services or supplies provided
- details of the charges for those services or supplies
- a diagnosis
- dates the services or supplies were provided
- patient’s name
- provider’s name, address, phone number, professional degree or license, and federal tax identification number

Please review your bills to make sure they are appropriate and correct. Report any discrepancies in billing to the HSBP Office. This can reduce the health care costs to you and the Plan.

Complete a separate claim form for each person for whom Plan benefits are being claimed. Make sure you keep copies of all bills and claim forms you submit.

Dental Claim Forms

You may send your dental claim forms for DentalGuard Preferred services to:

Guardian
P.O. Box 14094
Lexington, KY 40512-4094

Please note that if you are enrolled in the Guardian Managed DentalGuard (MDG), your dentist will file the claim form with Guardian.

There is a one-year limit beginning on the date of service to file a claim for benefits. You must file a claim for a Long-Term Disability Benefit within a reasonable period of time following the end of the Elimination Period for such claim. In addition, specific limits may apply to a claim for a dental benefit. If your claim is not filed within the applicable period of time beginning on the date of service, generally, no benefit will be paid. However, see the sections discussing these benefits.

Review Procedure If Your Claim Is Denied

If any claim is denied in whole or in part, the Plan will notify you in writing with reference to the Plan provisions on which the denial was based. When applicable, you will be told what additional information is required from you and why it is needed. You will then be entitled, upon written request, to a review of that claim decision.

Request for Review of Denial of Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing within 180 days after you receive notice of denial, to the applicable organization as listed below:

Discretionary Authority of the Trustees and their Designees

In carrying out their respective responsibilities under the Plan, the Trustees and other Plan fiduciaries and individuals to whom responsibility of the administration for the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan and to decide any factual questions related to eligibility for and entitlement to Plan benefits. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until 60 days have elapsed since you filed a request for review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. (No lawsuit may be started more than 3 years after the time proof of claim must be given.) Special rules may apply to certain dental benefits. Call the Plan Office for information.

Policies and Certificates Insurance Contacts Govern

This booklet describes the principal features of your Benefit Plan. The complete terms of the Insured coverage are set forth in the insurance policies issued by the insurance carriers. Individual certificates of insurance are available to you upon request. The HSBP Office will give or mail to you a copy of the policy if you call or mail your request. In the event of any question regarding the interpretation of these certificates or the proper payment of benefits, you can obtain information from the HSBP Office.

If there is any inconsistency between this Summary Plan Description and the insurance contracts, the insurance contracts will govern.

CLAIMS REVIEW AND APPEAL PROCEDURE

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. The addresses and procedures for Guardian and Davis Vision are located in their relevant appeal procedure sections. All other appeals can be submitted directly to the HSBP Benefits Plan Office. If your claim is reviewed by the carrier and you continue to be dissatisfied, you may appeal to the Board of Trustees in writing at HSBP Benefits Plan Office,

Remember, before you request an appeal from the HSBP, your claim must be reviewed by the relevant insurance carrier (if applicable). For reviews and appeals for claims other than Guardian claims, contact the Benefits Plan Office.

In all communications about a claim, be sure to include your identification number and group number.

A. Authority of the Plan

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

B. Request for Review of Disputed Claims

If you have presented a claim for benefits under this SPD, you may file a request for review of its disposition or adverse benefit determination by appealing to the Board of Trustees of the Plan in writing, within 180 days after receiving written notice of the Plan's action. Send your appeal to the Plan office. You will be notified, in writing, of the decision of the Board of Trustees within 60 days (45 days for disability claims) of the date your request for review is received, unless there are special circumstances, in which case you will be so notified and then notified of the decision within 120 days (90 days for disability claims).

If your claim is a Guardian dental claim MDG, call Guardian Member Services at 1-888-618-2016. If your claim is a Guardian dental claim PPO, call Guardian Member Services at -800-541-7846. You can also address your complaint, grievance or appeal to:

The Guardian
Attention: Appeals Department
P.O. Box 2457
Spokane, WA 99210-2457

C. Additional Information

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

D. Finality

In deciding claims, the Board of Trustees has broad discretion to interpret and apply the terms of this Plan and Summary Plan Description.

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

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

E. Notification and Right to Commentary and Information

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

F. Medical Judgments

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

COORDINATION OF BENEFITS

Important Notice

This section applies to all health benefits which pertain to employees of HSBP.

Purpose

When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

Allowable Expense

This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim

This term means a request that benefits of a plan be provided or paid.

Claim Determination Period

This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination of Benefits

This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent

This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan

This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice, and individual practice plans. This term also does not include: (i) blanket school accident type coverage or such coverage issued to a substantially similar group; or (ii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description. Each type of coverage listed above is treated separately. If a plan has

two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan

This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan

This term means a plan that is not a primary plan.

This Plan

This term means the group health benefits, except prescription drug coverage, if any, provided under this group plan.

Order of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

Non-Dependent or Dependent

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Child Covered under more than One Plan

The order of benefit determination when a child is covered by more than one plan is:

(1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

(2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

(3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active or Inactive Employee

The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length of Coverage

The plan that covered the person longer is primary.

Other

If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect on the Benefits of This Plan**When This Plan Is Primary**

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right To Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

POLICIES AND CERTIFICATES

This document describes the principal features of your Benefit Plan. The complete terms of the insured coverage are set forth in the insurance policies issued by Guardian Life Insurance Company of America. Individual certificates of insurance are available to you upon request. The Benefits Plan Office will give or mail to you a copy of the policy if you call in or mail your request. In the event of any questions regarding the interpretation of these certificates or the proper payment of benefits, you can obtain information from the Benefits Plan Office.

LIENS, LAWSUITS, AND OTHER COMPENSABLE SOURCES

If you should suffer an illness or injury for which benefits under the Plan's coverage is payable, the following subrogation provision will apply.

If this illness or injury is the result of an accident for which payment may be available from another source, a claim may be submitted for these expenses and payment considered by the Trustees. It is possible that the Plan may advance benefit payment in order to assist you in your time of need. The Plan will have the right to recover any paid benefits from the responsible party. In addition, the Plan will have the right to recover any payments which were made to a covered individual and which caused a duplicate payment for the same expenses. The covered individual will cooperate with and assist the Plan in recovering any benefits for which other payment is available. Acceptance of benefits from the Plan automatically assigns to the Plan any rights to recovery of duplicate payments.

The Plan has a constructive trust and an equitable right to and lien with regard to any monies received by an employee or beneficiary and/or his or her attorney or representative from a third party to the extent of benefits as described above.

ADDITIONAL PLAN INFORMATION

1. The House Staff Benefits Plan of the Committee of Interns and Residents is administered by a Board of Trustees, all of whom are appointed by the President of CIR and approved by the CIR Executive Board. The names of the Trustees are available from the Plan office, and their address for HSBP business is: House Staff Benefits Plan, 520 Eighth Avenue, Suite 1200, New York, New York 10018.
2. The name of the Plan Administrator is the Board of Trustees of the House Staff Benefits Plan of the Committee of Interns and Residents. The address of the Board of Trustees and HSBP office is:

**House Staff Benefits Plan
520 Eighth Avenue, Suite 1200
New York, New York 10018**

The telephone number is (212) 356-8180. The fax number is (212) 356-8181. You may send e-mail to benefits@cirseiu.org.

3. The Employer Identification Number assigned by the Internal Revenue Service is EIN 13-6203291. The Plan number assigned by the Board of Trustees is 501. For purposes of

maintaining the HSBP's fiscal records, the year end date is December 31. The Board of Trustees has been designated as the agent for the service of legal process at its address above. Service of legal process may also be made upon a Plan Trustee.

4. Public employers make contributions to the Plan in accordance with Collective Bargaining Agreements between the Committee of Interns and Residents and themselves. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per year per House Staff Officer. Presently the New York City Health & Hospital Corporation (HHC), Westchester Medical Center, California HSBP hospitals, Los Angeles County hospitals, and Cambridge Health Alliance are contributing employers.
5. Benefits are provided from the Plan's assets, which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits for covered employees and eligible dependents and defraying reasonable administrative expenses. Some of these benefits are provided through insurance policies.
6. The Plan's assets and reserves are held in custody by Smith Barney, and are invested by Stacey Braun Associates, Inc., 377 Broadway, New York, New York 10013. The Plan's assets and reserves are invested in federal government securities and short-term investments.
7. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are fully described in the eligibility section.
8. All of the types of benefits provided by the Plan are set forth in the Schedule of Benefits section of the Eligibility, QMCSO and Family and/or Medical Leave section of this document. The complete terms of the life and dental benefits are set forth in the group insurance policies issued by Guardian Life Insurance Company of America. The complete terms of the Long-Term Disability benefits are set forth in the group insurance policy issued by the Guardian Life Insurance Company of America.
9. Employees and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employee organization is a sponsor of the Plan and, if so, the sponsor's address. The Plan is maintained pursuant to Collective Bargaining Agreements. A copy of any such Agreement may be obtained by employees and beneficiaries upon written request to the Plan Administrator, and is available for examination by employees and beneficiaries.
10. The Plan is a welfare plan and a group health plan.

COBRA MODEL GENERAL (INITIAL) NOTICE

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA ****

Entitlement to COBRA Continuation Coverage: In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

NOTE: Domestic Partners and children of Domestic Partners are NOT offered the ability to elect COBRA continuation coverage because Domestic Partners and children of Domestic Partners are not considered qualified beneficiaries.

This Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a person's COBRA rights.

COBRA Administrator: The Benefits Plan Office at HSBP - 520 Eighth Avenue, Suite 1200, New York, NY 10018-4181. Phone: (212) 356-8180, Fax: (212) 356-8181 - is responsible for the administration of COBRA, and the organization to whom you can direct questions about COBRA.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment.

"Qualified Beneficiary": Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new Spouse of an existing COBRA employee during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA employee but is not a "Qualified Beneficiary." This means that if the existing COBRA employee dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

"Qualifying Event": Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries ¹		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

¹ When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law, as noted below:

- a. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and
- b. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA Continuation Coverage for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on the Qualifying Event that occurred, and is measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (see section on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this section.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law.

A person can also become entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this section. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Procedure for Notifying the Plan of a Qualifying Event

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a “dependent child” under the Plan, you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.

That written notice should be sent to the Benefits Plan Office. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Plan Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the employee’s own employer should notify the Plan Office of an employee’s death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the Plan Office in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

- a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, have become entitled to Medicare, or
- b. **you notify the Plan Office** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the Plan Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual’s rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the subsection on Paying for COBRA Continuation Coverage that appears later in this section for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the Plan and employee’s share), plus an additional 2%. **If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the additional COBRA period.**

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

IMPORTANT

There will be no invoices or reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Plan Office.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the Plan Office **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a health care provider requests confirmation of coverage and you, your spouse or dependent child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your spouse or dependent child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the health care provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Plan Office to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee) are enrolled for COBRA Continuation Coverage, your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or employee to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Plan Office, an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extending COBRA When a Second Qualifying Event Occurs

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced (or legally separated), become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below). NOTE: Medicare entitlement is not a qualifying event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage *is* available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage *is* available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the qualifying event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered spouse or dependent child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if:

- the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
- the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan: To extend COBRA when a second qualifying event occurs, you must notify the Plan Office in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's right to extended COBRA coverage. The written notice must include your name, the second qualifying event, the date of the second qualifying event, and appropriate documentation in support of the second qualifying event, such as divorce documents.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the Plan no longer provides group health coverage to any of its employees;
2. The date the amount due for COBRA coverage is not paid in full on time;
3. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA;
4. The date the Qualified Beneficiary's lifetime benefit maximum is exhausted on all benefits;
5. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition the Qualified Beneficiary may have; [IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the last day of the month in which the Qualified Beneficiary is covered under the other group health plan.
6. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the qualified beneficiary, or the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
7. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA employees under the Plan).

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated, and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Plan Office determines that COBRA coverage will terminate early.

Entitlement to Convert to an Individual Dental Plan after COBRA Ends

At the end of the 18 or 36-month period of COBRA Continuation Coverage, you will be allowed to enroll in an individual conversion dental plan as provided by the Plan, if that right is offered by the Plan at the time your COBRA Continuation Coverage period runs out. You will be advised if conversion rights are available when your COBRA Continuation Coverage ends.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Plan Office:

1. within 31 days of a change in marital status (e.g. marry, divorce); or if you have a new dependent child; or
2. within 60 days of the date you or a covered dependent Spouse or child has been determined to be totally and permanently disabled by the Social Security Administration; or
3. within 60 days if a covered child ceases to be a "dependent child" as that term is defined by the Plan; or
4. promptly if an individual has changed their address, becomes entitled to Medicare, or is no longer disabled.

Brief Outline on How Certain Laws Interact with COBRA

FMLA and COBRA: Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA Qualifying Event. A Qualifying Event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the Qualifying Event in most cases, the last day of the FMLA leave. Note that

if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA: If an employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium) or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18, 29, or 36 month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

HIPAA Certification of Creditable Coverage When Coverage Ends

When your COBRA coverage ends, the Plan Administrator will automatically provide you and/or your covered Dependents (free of charge) with a HIPAA Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See the Eligibility chapter for the procedure for requesting a HIPAA Certificate of Coverage.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Fund Office.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Benefits Plan office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Plan office.

Plan Contact Information

The House Staff Benefits Plan Office is responsible for the administration of COBRA Continuation Coverage and can be reached at the address below:

**House Staff Benefits Plan
520 Eighth Avenue
Suite 1200
New York, NY 10018-4181
(212) 356-8180**

HIPAA PRIVACY PRACTICES OF THE HOUSE STAFF BENEFITS PLAN

The following describes how medical information about you may be used and disclosed and how you can get access to this information

By law, the House Staff Benefits Plan (the "Plan") is required to maintain the privacy of your Protected Health Information (PHI), information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Regulations cover the disclosure and use of protected health information, your individual rights regarding protected health information and special rules for plan sponsors, employers and service providers to plans. This notice describes how the Plan protects the PHI we have about you and may use your health information for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

The Plan **must** use and disclose your PHI to provide information:

1. To you or someone who has the legal right to act for you (your personal representative).
2. To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
3. Where required by law.

The Plan **has the right** to use and disclose you PHI for Payment and Health Care Operations For example:

1. **Payment.** The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.
2. **Health Care Operations.** The Plan may use or disclose health information for its own operations to facilitate the administration of the health plan and as necessary to provide coverage and services to all of the Plan's employees.

The Plan **may** use or give out your PHI for the following purposes under limited circumstances:

1. **For Treatment Alternatives and Health-Related Benefits and Services.** The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives and health-related benefits that may be of interest to you.
2. **For Disclosure to the Plan Sponsor (the Trustees of the Plan).** The Plan may disclose your health information to the plan sponsor (the Trustees of the Plan) for plan administration functions performed by the plan sponsor (the Trustees of the Plan) on behalf of the Plan. In addition, the Plan may provide summary health information to the plan sponsor (the Trustees of the Plan) so that the plan sponsor (the Trustees of the Plan) may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan also may disclose to the plan sponsor (the Trustees of the Plan) information on whether you are participating in the health plan.
3. **When Legally Required.** The Plan will disclose your health information when it is required to do so by any federal, state or local law.
4. **To Conduct Health Oversight Activities.** The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose

your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

5. **In Connection with Judicial and Administrative Proceedings.** As permitted or required by state law, the Plan may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.
6. **For Law Enforcement Purposes.** As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.
7. **In the Event of a Serious Threat to Health or Safety.** The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
8. **For Specified Government Functions.** In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.
9. **For Workers' Compensation.** The Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

By law, the Plan must have your written permission (authorization) to use or disclose your PHI for any other purpose that is not set out in this Notice. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

You have the following rights regarding your health information that the Plan maintains:

1. **Right to Inspect and Copy Your Health Information Held by the Plan.** A request to inspect and copy records containing your health information must be made in writing. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.
2. **Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.
3. **Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information.** You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request.
4. **Right to Receive Confidential Communications.** You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. The Plan will attempt to honor your reasonable requests for confidential communications.

5. **Right to Receive a Listing of Those Receiving Your PHI from the Plan.** You have the right to request a list of certain disclosures of your health information, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing, specifying the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years.
6. **Right to a Paper Copy of this Notice.** You have the right to paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive it electronically.

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to:

***Earl Mathurin, Privacy & Security Officer
House Staff Benefits Plan
520 Eighth Avenue, Suite 1200
New York, NY 10018***

NOTICE OF ELECTRONIC DISCLOSURE

The following guidelines pertain to the use of electronic notices by the Plan. When you consent to this agreement, either by checking off the electronic notification box on your enrollment form, or by completing a paper or electronic version of this agreement sent to you by the Benefits Office, you are consenting to the following:

The CIR/SEIU Benefits Plan may, at times, send Notices by e-mail to Plan participants who have consented to receive information electronically. These Notices include: information regarding open enrollment, plan amendments, your benefits, changes to your benefits, the benefits booklet (commonly known as Summary Plan Description or SPD), news and updates about your benefits, summary annual reports, COBRA notices, newsletters, and other employee benefit Notices. Notices may also be available on the internet at www.cirseiu.org/benefits. Completing this consent form does not guarantee that all communications will be sent electronically and the Plan may at times send communications via first class mail.

By submitting this consent form, you understand and agree to the following terms and conditions:

Privacy: By law, the Benefits Plan cannot use your information without your permission, except as described in our Notice of Privacy Practices located in the SPD.

Contact Information: You are responsible for ensuring the Plan has a current e-mail address for you at all times for electronic communications. If your e-mail address changes at any time, you must notify the Plan in writing or by sending an email to benefits@cirseiu.org. Any communication sent by the Plan to the most recent e-mail address on file will be deemed delivered to you.

Cancellation: You can withdraw your consent at any time by contacting the Plan in writing or by sending an email to benefits@cirseiu.org.

Flexibility: You have the right to request a paper copy of any electronic notice sent to you, free of charge.

Hardware/Software Requirements: You must ensure that you are able to receive information electronically and retain it. You must have a computer system with an Internet Web browser capable of 128-bit encryption, and Adobe Acrobat Reader. You must have a printer capable of printing any disclosure made available on our website and/or emailed to you, or have the ability to electronically save such documents.

Risks: The Plan can't promise security and/or confidentiality when e-mailing. Although unlikely, it is possible an e-mail may be incorrectly shared or intercepted by someone other than the party to whom it was addressed. By completing this consent form, you understand these risks, and cannot hold the Benefits Plan responsible if such an event occurs.

Consent

I consent to the electronic disclosure by the Plan of all employee benefit Notices. I acknowledge that I have read the "Notice of Electronic Disclosure" and understand that I am entitled to withdraw my consent at any time with written notice to the Plan. I understand the risks associated with the use of electronic communications, and assume all risks and responsibilities. I understand that I can receive a paper copy of all employee benefit Notices upon request at no charge. I also confirm that I have the ability and software to access the internet, and to view the documents.

USERRA

Leave for Military Service

A employee who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Benefit Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your employer.

Reinstatement of Coverage After Leaves of Absence:

- **If your coverage ends while you are on an approved leave of absence for family, medical or military leave**, your coverage will be reinstated on the day you return to active employment, if you return immediately after your leave of absence ends, subject to all accumulated Overall and Annual Maximum Benefits that were incurred prior to the leave of absence.
- **If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave**, your coverage will be reinstated on the day you return to active employment, if you return immediately after your leave of absence ends, subject to any Overall and Annual Maximum Plan Benefits that were incurred prior to the leave of absence.

Any period of any approved leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will **not** be counted as a Break in Coverage. Questions regarding your entitlement to an approved leave of absence and to the continuation of medical and dental coverage should be referred to your employer

STATEMENT OF PARTICIPANT RIGHTS

The House Staff Benefits Plan of the Committee of Interns and Residents is not covered by the Employee Retirement Income Security Act of 1974 (ERISA) because the House Staff Benefits Plan covers governmental employees. The Trustees have agreed, however, to accord employees the rights described below, which are typically available under ERISA funds. Employees will be entitled to:

- Examine, without charge, at the Plan Manager's office all Plan documents, including insurance contracts, collective bargaining agreements and other documents such as annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Manager. The Plan Manager may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report.
- The Trustees who operate your Plan, called "fiduciaries," recognize that they have a duty to do so prudently and in the interest of you and other Plan employees and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under the Plan. If your claim for a benefit is denied, in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim and you have a right to appeal the decision to the Board of Trustees.



HSBP
520 Eighth Avenue, Suite 1200
New York, NY 10018

Phone: (212) 356-8180
Fax: (212) 356-8181
E-Mail: benefits@cirseiu.org
web: www.cirseiu.org/benefits

