INSIDE

UNIVERSITY PHYSICIANS BROOKLYN, INC.

2011-2012 BENEFIT OPTIONS at a glance

UPB recognizes the important role employee benefits play as a critical component of overall compensation, and we continue to make every effort to provide the best quality benefit plans for our staff and their families.

Once again it's our Open Enrollment period for our Medical and Vision Plans, which means you have the opportunity to evaluate your benefit needs and make benefit elections for the coming year. During this time you may revise or cancel your current medical benefit elections. These changes will be in effect October 1, 2011 through September 30, 2012. Except for the Open Enrollment Period, you may only make a modification to your coverage if you experience a qualified change in family status (e.g. birth/adopt a child, marriage, divorce, etc.).

A separate open enrollment period will be held at a later time for dental benefits and the flexible spending account plans. Please take the time to read all materials carefully prior to making your benefit elections.

Medical Plan

Aetna continues to offer the most competitive rates, benefits and network for our medical plan. Due to increases in the cost of our medical insurance, we will, for the first time in over 5 years, be making a few changes to the Aetna Basic and High POS medical plans effective October 1, 2011:

- $15 copay (previously $10 copay)
- Annual Deductible: $1,000 Individual/$3,000 Family—Basic Plan; $500/$1,000—High Plan (previously $700/$2,100—Basic Plan; $250/$500—High Plan)
- Out of Pocket Maximum: $5,000 Individual/$11,000 Family—Basic Plan; $1,500/$3,000—High Plan (previously $4,700/$10,100—Basic Plan; $1,250/$2,500—High Plan)

We are pleased to inform you that there will not be any changes to the current employee contributions.

Vision Plan

Davis Vision will continue to be our provider for our vision plan. They offer the most competitive rates, benefits and network for our employees. No changes have been made to the current plan or contributions.

The Open Enrollment period for the 2011—2012 plan year begins now and ends on October 7, 2011.

Actions to Take for 2011	
If you want to:	**Here's what you must do by October 7, 2011:**
Verify your Medical Benefits Coverage and ask questions about the how the Aetna Medical plan works	Dial 1-800-962-6842 and provide the UPB Group Number: 819825
Verify your Vision coverage and ask questions about how the Davis Vision plan works	Dial 1-800-999-5431 and provide the UPB Group Number: 7231
Continue with your current medical and vision coverage	Do nothing! You'll be enrolled with Aetna medical, effective October 1, 2011
Change, add to or cancel your current medical and vision coverage	Complete the enclosed Benefit Enrollment/Change form and fax to Human Resources 718-613-8715

comparison chart of medical plan options

Aetna®

BENEFIT	OPEN ACCESS MANAGED CHOICE BASIC POS PLAN IN-NETWORK	OPEN ACCESS MANAGED CHOICE BASIC POS PLAN OUT OF NETWORK	OPEN ACCESS MANAGED CHOICE HIGH POS PLAN IN-NETWORK	OPEN ACCESS MANAGED CHOICE HIGH POS PLAN OUT OF NETWORK
Annual Deductible	Individual: None Family: None	Individual: $1,000 Family: $3,000	Individual: None Family: None	Individual: $500 Family: $1,000
Out of pocket Maximum	Individual: Not Applicable Family: Not Applicable	Individual: $5,000 Family: $11,000	Individual: None Family: None	Individual: $1,500 Family: $3,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care				
Adult physical exams (Age 19 & Over); 1 exam every 2 years	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Well-child care (through age 18)	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Immunizations	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Annual GYN exam	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Outpatient Care				
Primary care physician office visits	$15 copay	70% coinsurance after deductible	$15 copay	80% coinsurance after deductible
Specialist office visits	$15 copay	70% coinsurance after deductible	$15 copay	80% coinsurance after deductible
Allergy Care				
Initial visit, and all subsequent visits	$15 copay	70% coinsurance after deductible	$15 copay	80% coinsurance after deductible
Hospital Care				
Physician's and surgeon's services	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Semi-private room and board	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
All drugs and medication	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Emergency Care				
Ambulance when medically necessary	No charge	No charge	No charge	No charge
At hospital emergency room	$50 copay, waived if admitted	$50 copay, waived if admitted	$50 copay, waived if admitted	$50 copay, waived if admitted
Maternity Care				
Prenatal and Post-natal care	$15 copay	70% coinsurance after deductible	$15 copay	80% coinsurance after deductible
Hospital services for mother and child	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Mental Health				
Inpatient	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Outpatient	$15 copay	70% coinsurance after deductible	$15 copay	80% coinsurance after deductible
Durable Medical Equipment	No charge	70% coinsurance after deductible	No charge	80% coinsurance after deductible
Prescriptions				
Retail Pharmacy	$10 Generic, $20 Brand, $35 Non-formulary copay	70% coinsurance after $10 Generic, $20 Brand, $35 Non-formulary copay	$5 Generic, $10 Brand, $25 Non-formulary copay	80% coinsurance after $5 Generic, $10 Brand, $25 Non-formulary copay
Mail Order (*You can receive up to a 90-day supply of medicine with mail order, for the cost of a 60-day supply from a retail pharmacy)*	Two times retail copay	In-Network Only	Two times retail copay	In-Network Only

TAKE A TOUR AROUND "aetna.com"

When you participate in an Aetna plan and register at **www.aetna.com**, a whole new world of information is at your fingertips. This website provides a wide range of resources. For example, you can:

- Search for in-network providers
- Print a temporary medical ID card at any time and request a permanent ID card
- Download and print forms, such as claim forms and mail order prescription drug forms
- Find the list of participating retail pharmacies and brand name drugs to help you save on the cost of your retail prescriptions
- Compare costs, fill your prescriptions online and track your medical claims
- Take a personalized health assessment and find out what you need to focus on to lead a long and healthy life
- Access libraries to learn about health conditions, symptoms and treatments

Who's Eligible?

As a regular, full-time employee, working 30 hours per week or more, you are eligible for the benefits described in this overview. You can also cover family members including your:

- Spouse
- Same-sex domestic partner
- Dependent children who are:
  - Under age 26 or
  - Over age 19 if disabled be-fore age 19 and dependent upon you for support.

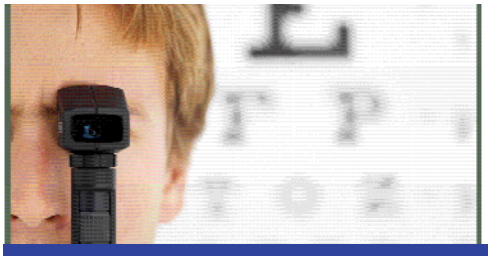
Marriage, Birth Certificate, and/or Adoption paperwork must be provided for enrolling a spouse or child(ren). A Declaration of Domestic Partnership form, with three types of proof, must be provided for enrolling a domestic partner.

Stay well, get fit and save money

Aetna's programs and services are your ticket to the small luxuries that keep you happy and healthy. Start today with Aetna and benefit from the abundant resources and tools designed to help you put your health first. You can:

- Find gym membership discounts, weight management and smoking cessation programs.
- Use discounts on services and supplies not covered under the High Plan or Basic Plan, such as acupuncture, massage therapy and nutrition counseling.
- Learn about complementary and natural alternatives to traditional care.
- Join a Healthy Pregnancy program at no cost and take a pregnancy assessment, get 24-hour toll-free access to experienced nurses and receive important information on every aspect of your pregnancy.

These are just a few of the services available through Aetna. You can visit ***www. aetna.com***, 24 hours a day, for more information.



comparison chart of vision plan options

DAVIS VISION™

BENEFIT	IN-NETWORK	OUT OF NETWORK
Exam	$10 copay	Up to a maximum reimbursement of $30
Frequency		
Exam, Lenses, Contact Lenses	12 months	12 months
Frames	24 months	24 months
Eye Exam	Covered in full after copay	Up to a maximum reimbursement of $30
Frames	Covered in full for Premier Collection; $50 allowance all others	Up to a maximum reimbursement of $30
Lenses		
Single Vision Lenses	Covered in full	Up to a maximum reimbursement of $25
Bifocal Vision Lenses	Covered in full	Up to a maximum reimbursement of $35
Trifocal Vision Lenses	Covered in full	Up to a maximum reimbursement of $45
Lenticular Vision Lenses	Covered in full	Up to a maximum reimbursement of $60
Contact Lenses (medically necessary with prior approval)	Covered in full	Up to a maximum reimbursement of $225
Elective Contact Lenses	Covered in full for 6 month supply for Plan contacts; $115 allowance for non-plan contacts	Up to a maximum reimbursement of $75

Legislative Updates

Newborns' and Mother's Health Protection Act of 1996 (Newborn's Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization form the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Qualified Medical Child Support Order (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Legislative Updates

Janet's Law

On October 21, 1998, Congress enacted the Women's Health and Cancer Right Act of 1998. As required by this law, annual notice of the mandated post-mastectomy benefits must be provided to all covered persons.

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedamus.

The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act; Penalizing, reducing, or limiting reimbursement to the attending provider (e.g. physician, clinic or hospital) to induce the provider to provide care inconsistent with the Act; and
- Providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the Act.

Michelle's Law

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan.

Coverage will be continued until:

(1) one year from the start of the medically necessary leave of absence, or
(2) The date on which the coverage would otherwise terminate under the terms of the health plan, whichever is earlier.

Pre-Existing Condition of Notification (HIPAA)

A group health plan may not impose a pre-existing condition exclusion with respect to a participant or dependent before notifying the participant, in writing, of:

- The existence and terms of any pre-existing condition exclusion under the plan;
- The rights of individuals to demonstrate creditable coverage (and any applicable waiting periods);
- The right of the individual to request a certificate from a prior plan or issuer, if necessary; and,
- That the current plan (or issuer) will assist in obtaining a certificate from any prior plan or issuer, if necessary.

Legislative Updates

Coverage Extension Rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Special Enrollment Rights CHIPRA—Children's Health Insurance Plan

Effective April 1, 2009 you and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.

You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Notice of Privacy Practices (HIPAA)

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health-related information. The Notice of Privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your employer.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you do not meet one of the rules above, you will not be allowed to modify your election until the next open enrollment period.

To request special enrollment or obtain more information contact: Raquel Nurse, Director - Human Resources, 718-804-7808.

benefits call center

NO MORE HEADACHES

resolving healthcare benefits issues!

Call us today! Your personal team of healthcare benefits experts are ready to give you, and your family, the attention they deserve!

This hotline is staffed by benefit professionals from **8:30am to 8:00pm Monday through Friday** (EST). These specialists are available to help whenever you encounter a problem with Aetna, Delta Dental, Davis Vision, Reliance Standard, Cigna or with any of the following topics:

- Benefits questions
- ID card issues
- Questions regarding bills/claim and resolutions
- Prescription issues
- Provider network questions
- COBRA
- ...and much more!

No more calls to your carrier and being stuck on hold waiting for assistance. A majority of issues are resolved the same day. "ONE CALL DOES IT ALL!," and ***all calls are fully HIPAA compliant.***

For personal service that's **CONFIDENTIAL** and **RESPONSIVE**, contact:

1.866.286.5334

or email us at Questions@benefitsvip.com

ONE CALL DOES IT ALL!

Important plan information

Plan/Group Number	Provider	Phone Number	Internet Address
Medical (819825)	Aetna Medical POS	800-962-6842	www.aetna.com
Dental (NY06097)	Delta Dental of NY PPO	800-932-0783	www.deltadentalins.com
FSA (86318830)	Aetna	866-472-0897	www.myaetnafunds.com
Vision (7231)	Davis Vision	800-999-5431	www.davisvision.com
Short Term Disability (159319)	Reliance Standard Life Insurance Co.	800-559-0954	www.reliancestandard.com
Long Term Disability (117390)	Reliance Standard Life Insurance Co.	800-559-0954	www.reliancestandard.com
Employee Assistance Program	Reliance Standard Life Insurance Co.	800-767-5320	www.my-life-resource.com Login: hmsa; Password: myresource
Profit Sharing Plan with 401(k) Provisions TIAA CREF (347143) CITIGROUP Smith Barney (01-0588836) Sanford Bernstein (T03500290)	**TIAA CREF** - Catie Keane ckeane@tiaa-cref.org **CITIGROUP** Smith Barney - Steven Loeb steven.a.loeb@smithbarney.com **Sanford Bernstein** - Customer Service	516-454-4009 800-227-6121 504-585-3942 800-774-5543	www.tiaa-cref.org www.smithbarney.com www.bernstein.com/informedchoice

This benefit summary provides selected highlights of the employee benefits program at UPB. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at UPB. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. UPB reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.