The Continuum Benefits Program

Your Health & Welfare Summary Plan Description

January, 2009

Continuum Health Partners, Inc.

Beth Israel

St. Luke's Roosevelt

LICH Brooklyn

This Summary Plan Description describes the Continuum Benefits Program in a quick, easy-to-understand way. It provides a general overview of, and is much shorter and less technical than, the legal documents and contracts that govern our benefits. Although Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, and Long Island College Hospital have made every effort to have this enrollment guide accurately reflect those documents and contracts, if there is any conflict or inconsistency, the documents and contracts will govern.

Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, and Long Island College Hospital, by their Boards of Trustees, and as delegated by the Plan Administrators, reserve the right, in their sole and absolute discretion, to amend, modify, delete, or terminate the benefits program, in whole or in part, at any time and for any reason for all employees, active and retired. If the program is so amended, modified, deleted, or terminated, your right to participate in, or to receive benefits under the program may be changed or eliminated. In addition, in the event that the program is amended, modified, deleted, or eliminated, the benefits coverage provided to you and your eligible dependents under the program may be changed or eliminated. Under no circumstances will any benefit under this program ever vest or become nonforfeitable.

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Introduction

This booklet contains a summary plan description of the Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, and Long Island College Hospital health and welfare benefits program. The descriptions provide you with an overview of the plans and legally required information. We believe that you will find this booklet a valuable tool when you have questions about the health and welfare benefits program.

If you have questions after reading this booklet, call the Benefits Office at 212-523-5193.

Benefits at a Glance

The benefits program offers two types of plans.

- There are *non-elective* plans that are provided to you at no cost- such as basic life insurance, short-term disability, basic long-term disability and business travel accident insurance. You do not enroll for coverage in these plans.
- The other plans are *elective* plans. If you elect coverage, either you and/or your employer share the cost OR you pay the full cost of coverage. These plans include: medical, dental, health and dependent care flexible spending accounts, additional life insurance, accidental death and dismemberment insurance, additional long-term disability. There is an annual open enrollment period for your elective plans.

The following table provides a brief summary of the benefits program.

Benefit Plan	Description
Medical	You may choose from three medical options: Empire PPO, Empire EPO, HIP 70% POS (HIP 70% POS is not offered by LICH or DOCS). You may also decline coverage under certain circumstances. You and your employer share the cost of coverage.
Prescription Drugs	If you elect medical coverage through Empire, you will automatically be covered for prescription drug coverage through Medco. If your medical selection is HIP 70% POS prescription coverage is provided through HIP.
Dental	You may choose between the Guardian DentalGuard Preferred PPO Plan and the Empire Managed Dental Plan. You and your employer share the cost of coverage. If you elect dental coverage you will automatically be covered for vision coverage with UnitedHealthcare, and a hearing benefit, which is self-insured through Continuum.
Health Care Spending Account	You may set aside up to $3,000 each year on a before-tax basis to pay most of your family's out-of-pocket health care expenses.
Dependent Care Spending Account	You may set aside up to $5,000 each year on a before-tax basis to pay for dependent care. If you are married, your spouse must also work for you to be eligible for coverage.

Benefit Plan	Description
Short Term Disability (STD)	If you are unable to work because of illness or injury, this plan partially replaces your income for up to 26 weeks. Benefits begin after you use all accrued sick time. Your employer pays most of the cost of this coverage; you pay only a small share.
Long Term Disability (LTD)	If you remain continuously disabled beyond the 26-week waiting period, your employer provides LTD that pays 50% of your base salary, with a maximum monthly benefit of $2,000. You may also purchase additional LTD coverage. For BI/SLR, combined coverage would equal 60% of your base salary, with a maximum monthly benefit of $10,000. For LICH, combined coverage would equal 66⅔% of your base salary, with a maximum monthly benefit of $8,000.
Basic Life Insurance	Your employer provides basic life insurance equal to one times your annual base salary (rounded to the next $1,000), to a maximum of $500,000.
Additional and Dependent Life Insurance	If you want additional life insurance, you may purchase one, two, three, four, or five times times your annual base salary up to $750,000. Your benefit will be rounded to the next $1,000. The combined maximum for basic and additional life insurance coverage is $1,250,000. You may also purchase life insurance for your spouse and children in the amounts of $5,000, $10,000, $15,000, or $20,000 for your spouse and $4,000 for each of your children up to age 19, or up to 25 if full-time students. This coverage is not available for domestic partners or their children. LICH is excluded from any option that includes children. The combined maximum for basic and additional life insurance coverage is $1,250,00. You may also purchase life insurance for your spouse in amounts of $5,000, $10,000, or $15,000, and $4,000 for each of your children up to age 19, or 25 if full-time students. This coverage is not available for domestic partners (as provided in the collective bargaining agreement).
Accidental Death & Dismemberment (AD&D) Insurance	You may purchase accidental death and dismemberment insurance equal to two times your annual base salary, rounded up to the next $1,000, to a maximum benefit of $500,000. This coverage pays a benefit if you die, become dismembered, or lose your eyesight as a result of an accident. The amount of the benefit is determined by your loss.
Business Travel Accident Insurance	Your employer provides coverage if you die or are dismembered while on hospital business-related travel. This coverage is in addition to your basic life insurance. Your employer pays the entire cost of this coverage. LICH is excluded from the Business Travel Accident Insurance benefit.

Important Notice from Continuum About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Continuum and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Continuum has determined that the prescription drug coverage offered by the Continuum Benefits Program is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Continuum prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Continuum and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact the Benefits Office at 212-523-5193

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Continuum changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Name of Entity/Sender:	Continuum Health Partners
Contact – Position/Office:	Pamela Abner, AVP, Human Resources
Address:	555 West 57th Street, New York , NY 100019
Phone Number:	212-523-5193

Eligibility for Benefits

Beth Israel Medical Center/ St. Luke's-Roosevelt Hospital Center

You are eligible for coverage if you are in an eligible employee class and if you are a full-time or half-time non-temporary employee working at least 17.5 hours per week. You are in an eligible employee class if you are a non-union employee OR if you are a union employee whose collective bargaining agreement provides for coverage in the hospital's plan.

For Local 153, you are eligible for coverage if you work 20 hours or more per week as provided for in the collective bargaining agreement.

Non-temporary part-time employees who regularly work less than 17.5 hours per week are eligible only for Short-term Disability coverage after you work 24 regular employment days. Part-time employees become eligible on the 25th day of regular employment. There is no need to enroll in this benefit. You will be automatically enrolled for Short-term Disability coverage once you meet the above criteria.

Long Island College Hospital

You are eligible for coverage if you are in an eligible employee class and if you are a full-time or part-time non-temporary employee working at least 12.5 hours per week. You are in an eligible employee class if you are a non-union employee OR if you are a union employee whose collective bargaining agreement provides for coverage in the hospital's plan.

Non-temporary part-time employees who regularly work less than 12.5 hours per week are eligible only for Short-term Disability coverage after you work 24 regular employment days. Part-time employees become eligible on the 25th day of regular employment. There is no need to enroll in this benefit. You will be automatically enrolled for Short-term Disability coverage once you meet the above criteria.

Eligible job classifications include:

- Non-union clerical
- Supervisor
- Manager or Director
- Executive
- Physician (excluding Interns and Residents at St. Luke's-Roosevelt Hospital, and DOCS physicians subject to the parameters described above)
- Physical Therapist (APTA)
- Physician Assistant (excluding Beth Israel Medical Center)
- Local 153
- Interns and Residents at Beth Israel Medical Center and Long Island College Hospital

Enrollment for Benefits

You are able to make benefit elections only when you are first hired **OR** once each year during open enrollment. You will not have the opportunity to change your benefit selections again until the next open enrollment period unless you have a qualifying family status change. (See page 9 for information on status changes.)

Open Enrollment

Any changes you make during open enrollment will be effective for the upcoming year – January 1 through December 31 – provided you continue to meet the eligibility requirements. You only need to re-enroll if you are making changes to your current benefit elections OR if you wish to contribute to the Flexible Spending Accounts. If you do not re-enroll, your current benefit elections will remain in force at the new contribution level, excluding Flexible Spending Accounts. In this case, you will not be able to contribute to the Flexible Spending Accounts in the following year.

New Hires

If you are a newly hired employee, **you must actively enroll for coverage within 30 days of your date of hire**. Your coverage becomes effective 30 days after your date of hire. Once you make your selection, you may not make a change unless you have a qualifying family status change. You will have an opportunity to change your coverage during the next open enrollment period.

If you fail to enroll, you will be placed in the default coverage, as described on page 51.

How to Enroll

Your benefits information will be available to you via an on-line enrollment system. You will be able to access your current benefits information and enroll for new coverage. You may access the system from any computer with Internet access (home, office, library or at specified hospital locations). For more information on the enrollment process, see page 51.

Who Is Eligible for Coverage

In addition to enrolling for your own benefits coverage, you may enroll your eligible dependents for the following coverage:

- Medical
- Dental/Vision(hearing coverage is not available for dependents)
- Dependent Life Insurance

Any dependent you enroll will receive the same medical and dental/vision coverage that you choose for yourself. Dependent life insurance coverage is not available for domestic partners and /or their children.

Eligible dependents include:

- Your legal spouse.
  - In order to enroll for coverage, you must provide proof of marriage.
- Your domestic partner of the same or opposite sex. In order to enroll a domestic partner in one of these plans, you and your domestic partner must either:
  - be domestic partners registered with the City of New York, or
  - meet the requirements for domestic partner registration in the City of New York, or
  - be parties to a marriage, civil union or domestic partnership entered into in a state other than New York, even if the union is not recognized in New York.
  - In order to enroll for coverage, you and your domestic partner must provide documentation of your relationship. If your domestic partnership is registered with the City of New York, you should provide a certificate of registration. If you are parties to a marriage, civil union, or domestic partnership entered into in another state, you should provide a copy of the documentation issued by that state. If your domestic partnership has not been solemnized, you may still enroll by providing an affidavit, signed by both of you, stating that:
    - You are both 18 years old or older.
    - Neither of you is married.
    - Neither of you is a party to another domestic partnership.
    - Neither of you is related to each other by blood in a manner that would bar your marriage in the state of New York.
    - You have a close and committed personal relationship, live together, and have been living together on a continuous basis.
- SLR, BI, and LICH reserve and retain the sole right to determine if a sufficient showing of domestic partnership has been made.
- Your unmarried child(ren) up to age 19, or to age 25 if a full time student at an accredited college or university and wholly dependent on you for support and maintenance.
- Your unmarried handicapped child over age 19 who cannot support him/herself. You must provide proof of disability no later than one month prior to your child's nineteenth birthday.

Coverage continues until the end of the month in which your child(ren) reaches age 19 if wholly dependent on you for support and maintenance, or if between ages 19 and 25:

- the end of the year in which your child(ren) graduates or reaches age 25 if the child(ren) is wholly dependent on you for support and maintenance (if your child(ren) gains employment during that time, coverage ceases at the end of the month in which employment begins)
- the end of the month in which your child(ren) is no longer a full time student (and has not graduated)

Eligible children include your:

- natural children
- adopted children or children placed in your home for the purpose of adoption
- step-children who reside in your home and who are dependent on you for support and maintenance
- children for whom you have legal guardianship (you must provide a copy of legal guardianship document)
- domestic partner children (your domestic partner must also be covered for benefits)

In order to enroll for coverage, you must provide a copy of the child(ren)'s birth certificate.

When Coverage Begins

The effective date of coverage in the employer sponsored medical, dental, vision, hearing, life and long-term disability plans is as follows:

- If you are a new hire, your medical, dental, vision, hearing, life and long-term disability coverage becomes effective 30 days after your date of hire.
- If you are a non-union employee in an ineligible job class, such as per diem or temporary, and transfer to an eligible job class, coverage becomes effective as of the date of your eligible job class change (provided you have been an employee for at least 30 days).
- If you are an employee covered by a collective bargaining agreement and transfer into a job class eligible for benefits under the employer sponsored plans, your effective date of coverage will depend on your previous job classification. Contact the Benefits Office at (212) 523-5193.

Paying for Coverage

You and your employer share the cost of your benefits coverage. Your employer pays the majority of the premium for your health benefits. You are required to make a contribution towards the cost of your benefits coverage. Your share of the cost for each benefit option is provided on-line when you enroll.

Medical Coverage

Medical coverage contribution rates will be equitably distributed according to employee salary levels. For employees working 30 hours or more weekly, your annual base salary will determine your contribution for medical coverage. This means that contributions for the medical plan will vary depending on employee salary level. For part-time employees – those scheduled to work less than 30 hours on a weekly basis – contributions will be at the 3rd tier ($70,000 - $99,000).

Dental/Vision/Hearing Coverage

Your contribution for dental coverage will be based on the dental plan that you choose. This cost also includes coverage for vision and hearing coverage. Refer to your on-line enrollment worksheet for costs.

Life and Long-Term Disability Insurance Coverage

Your contribution for additional life and/or additional long-term disability insurance will be based on your age and salary. Refer to your on-line enrollment worksheet for costs.

Coverage Levels

Your contribution for medical and/or dental/vision/hearing coverage also depends on which of the following coverage levels you elect. If you wish to cover yourself and only one dependent, you should select “employee plus one” (not “family”) when you enroll on-line.

- Employee only (coverage for yourself only)
- Employee plus one dependent (coverage for yourself plus your spouse/domestic partner **OR** coverage for yourself plus one dependent child)
- Employee plus family (two or more dependents)

Pre-tax Contributions

Your contributions for medical coverage, dental/vision/hearing coverage, and Flexible Spending Accounts are deducted on a pre-tax basis. This means that your contributions for these options are taken out of your pay before that money is taxed. As a result, your taxable income is lower and you pay less in taxes.

Your future Social Security benefits may be slightly lower if you make pre-tax contributions for an extended time period. In most cases, current tax savings offset the lower Social Security benefits you might receive in the future. However, individual taxes differ, so you should discuss your personal situation with your tax advisor.

After-tax Contributions

Your contributions for any additional life insurance, accidental death and dismemberment insurance, dependent life insurance and additional long-term disability you elect are made on an after-tax basis. This means that your contributions for these options are taken out of your pay after that money is taxed.

Tax Effect for Domestic Partners

If you elect coverage for a domestic partner [and his/her child(ren)], certain tax rules may apply. Unless your domestic partner and his/her child(ren) satisfy the definition of a dependent under Section 152 of the Internal Revenue Code, your contributions for your domestic partner’s and/or child(ren)’s coverage must be made on an after-tax basis. In addition, the “fair market value” of your partner’s/child(ren)’s coverage is taxable to you and is imputed as income. While the law is unclear on the precise definition of “fair market value,” a common approach defines the term as the difference between the premium value (total of employer and employee contribution) for covering both the employee and the domestic partner/child(ren) and the value of the coverage without the domestic partner/child(ren).

The imputed income calculation is extremely complex. You should seek the advice of a tax professional concerning the taxability of domestic partner coverage.

Qualifying Family Status Change

Choose Carefully

Choose your benefits coverage carefully. IRS rules will not allow you to change your coverage during the year unless you have one of the following qualifying family status changes, which affects your eligibility for coverage, as well as your participation in the Flexible Spending Accounts:

- A change in legal marital status due to marriage, divorce, death of a spouse, legal separation, or annulment.
- A change in your number of dependents due to the birth, adoption, placement for adoption, or death of an eligible dependent.
- A change in a child's status that makes the child eligible or ineligible for coverage (due to attainment of age, student status, employment or any similar circumstance).
- A change in employment status for an employee or spouse, including (i) termination or commencement of employment, (ii) a strike or lockout, (iii) a commencement of, or return from, an unpaid leave of absence, (iv) a change in worksite, and (v) if the eligibility conditions of the cafeteria or other employee benefit plan of the employer of the employee, spouse, or eligible dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan.
- A change in residence. If you move out of the medical and/or dental plan service area, you may choose a new medical and/or dental plan.
- Establishment or termination of domestic partnership.

If you experience one of these qualifying events and would like to make corresponding changes to your coverage level, **you must complete a Qualifying Family Status Change Form (available on the Intranet under Human Resources, Benefit Forms, or by contacting the Benefits Office at (212) 523-5193) and return it, along with supporting documents, to the Benefits Office within 30 days of the event.**

Do not delay your family status change notification to the Benefits Office. **The Benefits Office must receive your completed FSC form within 30 days of your qualifying event.** If you are awaiting supporting documents such as birth or marriage certificates, include a note with your completed FSC form that supporting document(s) will be forthcoming.

Any approved change is effective on the date of the event or the date following the date of the event depending on the type of qualifying event, in accordance with the guidelines of the plan in which you are enrolled.

Special Enrollment Periods

Enrollment for yourself and/or your eligible dependent(s) during the year, as a result of a qualifying change in status, is subject to the approval of the carrier with which you have selected coverage.

Take Note

- If you are enrolling dependents for the first time, you will be required to provide proof of eligibility before coverage takes effect.
- If you are enrolling your domestic partner or your domestic partner's child(ren) for the first time, you may want to discuss the tax implications of this coverage with a tax advisor.
- Employee benefit contribution changes resulting from employment changes such as full-time to part-time, transfers, promotions, etc., do not qualify as family status changes. You will not be able to change your benefit elections due to increases in benefit plan costs.

When Coverage Ends

Coverage in the employer sponsored medical, dental, vision, hearing, life and long-term disability benefits ends:

- on the day your employment ends if you voluntarily terminate employment
- at the end of the month in which your employment terminates if your employment is involuntarily terminated for reasons other than gross misconduct (e.g. layoff, budget reduction or performance)
- after six months if you are on an approved personal medical leave of absence
- after twelve weeks if you are on an approved family medical leave of absence (FMLA) other than a personal medical leave
- immediately when you cease to make required contributions
- immediately if you intentionally falsify your enrollment information or your claim for benefits
- immediately when you become eligible for Medicare and choose Medicare as your primary coverage
- immediately for any member of your family who no longer qualifies as an eligible dependent (except as specified under certain circumstances)
- on the effective date plan coverage ceases for the class of employees to which you belong
- on the effective date your employer terminates the plan

Qualified Medical Child Support Order ("QMCSO")

Federal law requires group health plans, to honor Qualified Medical Child Support Orders ("QMCSOs"). In general, QMCSOs are state court (or administrative agency) orders requiring a parent to provide medical support to a child, for example, in cases of legal separation or divorce where the child would otherwise not be eligible for coverage under the health plan.

A QMCSO may require the health plan to make coverage available to your child even though, for income tax or plan purposes, the child is not your dependent (e.g., your child does not reside with you). In order to qualify as a QMCSO, the medical child support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- Specifies your name and last known address, and the child's name and last known address;
- Provides a reasonable description of the type of coverage to be provided by the Plan, or the manner in which the type of coverage is to be determined;
- States the period to which it applies; and
- Specifies each plan to which it applies.

In addition, a National Medical Support Notice issued pursuant to ERISA Section 609(a)(5)(C) which has been appropriately completed and which satisfies the requirements listed above, will be deemed to be a QMCSO.

The QMCSO may not require the health plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the health plan. Upon approval of a QMCSO, the health plan is required to pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the health plan.

You and the affected child will be notified if an order is received and will be provided with a copy of the health plan's QMCSO procedure. A child insured under the health plan pursuant to a QMCSO will be treated as a dependent under the health plan. **Additionally, you or your beneficiaries may obtain, without charge, additional information or a copy of the procedures from the Plan Administrator.**

The Medical Plan

There are three medical options available under the Plan. You may waive medical coverage if you have other medical coverage through another group plan and provide proof of that coverage.

Medical Options

- Empire BlueCross BlueShield EPO
- Empire BlueCross BlueShield PPO
- HIP 70% POS (Not offered for LICH or DOCS)

Reminder: If you require information regarding a service not mentioned in this SPD, please refer to the underlying plan document, available from your Human Resources Department. Items or services which are not listed as covered in either the Plan document or the SPD are not covered.

Preferred Provider Organization (PPO) & Exclusive Provider Organization (EPO) Plans

A Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO) Plan does not require you to select a Primary Care Physician (PCP) to manage your care. You may receive care from an Empire BlueCross BlueShield PCP specialist without a referral from a PCP. The biggest difference between the Empire PPO plan and the Empire EPO plan is that the Empire EPO plan does **not** offer out-of-network coverage. You must utilize a participating provider to receive benefits. Other differences include the level of benefits for the same services under both plans and the employee contribution amounts.

You may obtain a list of participating providers on-line at www.empireblue.com.

Prescription Drug Coverage for Empire PPO and Empire EPO Plan Participants

Prescription drug coverage is provided through *Medco Health Solutions* for employees who participate in Empire PPO or Empire EPO.

Eligible prescriptions must be obtained through a Medco participating pharmacy or via mail order. Prescriptions purchased out-of-network will not be considered.

Prescription Drug Card Program

This program allows you to purchase up to a 30-day supply of prescription medication from participating pharmacies. To obtain information regarding participating Medco retail pharmacies, you may call Medco Health Solutions at (800) 711-0917 or visit their website at www.medcohealth.com.

The prescription *Generic* drug co-payment for up to a 30-day supply at a participating retail pharmacy is $5. For *Single Source* or *Multi-Source* drugs, your co-payment is 25% of the total cost, to a maximum of $60 for up to a 30-day supply.

The mail order service is mandatory for covered maintenance medications you take on a long-term basis (3 months or more). You will be able to purchase each long-term drug (up to a 30-day supply) at a participating retail pharmacy 3 times and pay your participating retail pharmacy co-payment. Beginning with the fourth time you purchase each long-term drug at a participating retail pharmacy, you will pay the entire cost of the drug. If you use the mail order service, you will only pay your mail-order co-payment for up to a 90-day supply.

Medco utilizes a generic choice program for both retail and mail order prescription drug coverage. This means if there is a **generic substitute available** for a brand name drug and you choose to receive a brand name drug, you will be subject to a co-payment for the brand name plus you will be required to pay the difference in cost between the brand name drug and its generic equivalent. If there is **no generic substitute** available, you will be subject to a co-payment for formulary and non-formulary brand name drugs.

Prescription Mail Order Program

This program provides a special mail order service for prescription drugs offered through a pharmacy service for up to a 90-day supply. This service is designed to be used in conjunction with *maintenance drugs* – that is, medications you need to take for chronic or long-term conditions and is in addition to regular coverage for non-maintenance drugs.

The prescription *generic* drug mail order co-payment for up to a 90-day supply is $10. For *brand name* drugs, formulary or non-formulary, your co-payment is 25% of the total cost, to a maximum of $120 for up to a 90-day supply.

You must purchase prescriptions through mail order service for any maintenance drugs after the third refill at a participating retail pharmacy.

If there is a **generic substitute available** for a brand name drug and you choose to receive a brand name drug, you will be subject to a co-payment for the brand name plus you will be required to pay the difference in cost between the brand name drug and its generic equivalent. If there is

no generic substitute available, you will be subject to a co-payment for formulary and non-formulary brand name drugs.

Covered Drugs

The following list is a general guide and is not meant to encompass every drug covered by the plan. Please contact Medco at (800) 711-0917 if you require information regarding a specific drug not referred to on the list.

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- OTC diabetic supplies (except Glucowatch/sensors)
- Inhaler assisting devices
- Preven, Plan B (retail only)
- Retin-A all dosage forms through age 35
- Oral, transdermal, intravaginal, and injectable contraceptives

Dispensing quantities will be limited for migraine medications, hypnotic agents (sleeping pills), anti-influenza, ED, and pain management drugs. Requests for greater drug quantities (above the plan limits) will require review by Medco via a coverage authorization process.

Drugs That Require Prior Authorization (to determine medical necessity)

You must use Medco's coverage review process in advance of obtaining the following prescription drugs to determine if the drug will be covered under the plan. Please contact Medco at (800) 753-2851 to speak to a managed care representative regarding the prior authorization process.

- Antineoplastic agents (Iressa)
- Xolair
- Dermatologicals (i.e. Tazorac, Retin A)
- Growth hormones
- Growth hormone receptor antagonists
- Erythroid stimulants
- Myeloid stimulants and Neumega
- Fertility medications (limited to $15,000 lifetime maximum
- Interferons
- MS agents
- SPA Ribavirin
- Androgen and anabolic drugs
- Anti-Narcoleptic agents (Provigil)

Step Therapy Program

Step Therapy is a specific type of coverage authorization that generally requires treatment to follow a progression of therapeutic options. This means that your plan will cover other safe and effective alternatives before any of the above listed drugs will be covered. The following prescription drugs are included in the Step Therapy program:

- Pain management
- Rheumatology drugs
- Celebrex
- Protopic
- Elidel
- Osteoporosis Therapy (i.e. Forteo)
- CNS stimulants / Strattera / Amphetamines
- Depression therapy (Wellbutrin SR & Wellbutrin XL)

Exclusions

The following list is a general guide and is not meant to encompass every drug excluded by the plan. Please contact Medco at (800) 711-0917 if you require information regarding a specific drug not referred to on the list.

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices, and implants
- Antiobesity medications
- Relenza, Tamiflu
- Preven, Plan B (under mail order only)
- Smoking deterrents
- Synagis or RespiGam
- Ostomy supplies
- Dental fluoride products
- Retin-A age 36 and older
- Yohimbine
- Glucowatch/sensors
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only (i.e. Renova®).
- Allergy Serums
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Drugs labeled "Caution – limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

Empire EPO

The Empire EPO consists of a comprehensive group of facilities and physicians from whom you may receive care. The Empire EPO is administered by Empire BlueCross BlueShield (Empire BCBS) and is comprised of two coverage networks. The primary network consists of any Empire BCBS participating provider or facility affiliated with SLR, BI, LICH or NYEE. The secondary network consists of any of the other providers in BlueCross BlueShield's extensive national network. There is **no** coverage for services received outside of the networks, other than for emergency services.

In-network coverage – If you receive your care from BI, SLR, LICH or NYEE Empire BCBS participating doctors, hospitals or ancillary providers, your co-payments will generally be either $0 or $10. You may also use any of the other providers in BlueCross BlueShield's extensive national network.

If you use a BCBS participating provider **not** affiliated with BI, SLR, LICH or NYEE, there is a $30 co-payment for basic physician office visits. You pay 20% coinsurance for other eligible physician office services.

Out-of-network coverage – If you receive care from a provider or at a facility that is not part of either network, there is **no coverage***,* except for emergency services (as determined by Empire). Emergency services and emergency-related hospital admissions outside of the Empire network are covered at 80%. If you have an emergency out of network, Empire will attempt to transfer you to a participating hospital, provided you are stable.

In order to receive coverage under the Empire EPO Plan, you must seek care from a physician or facility that participates in the BCBS networks.

Air ambulance coverage – This benefit covers emergency air ambulance transport to the nearest acute care facility when ground transportation is not available. The ensure full coverage, Empire's Medical Management department must authorize in advance, when feasible, or within 48 hours after admission with the use of an air ambulance. The following conditions must be met:

- A covered person's medical condition must requires immediate and rapid ambulance transportation, and services cannot be provided by land ambulance due to great distances or other geographical obstacles, and the use of land transportation would pose immediate threat to the covered person's health.
- Services will be covered for an air ambulance used to transport a covered person from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for the covered for the covered person's treatment as determined by Empire, and use of a land ambulance would pose an immediate threat to the covered person's health.

Mental Health coverage – In-network mental health and substance abuse services are provided through the Behavioral Health Program.

In order to receive coverage for in-patient and outpatient mental health or substance abuse care provided in-network, you must obtain authorization in advance by calling the Behavioral Health Program at (800) 626-3643. You will be sent a written confirmation of the authorized services.

Empire EPO Medical Plan Benefits Summary

Following is a brief overview of your coverage. **Providers in both the CHP Network (SLR/BI/LICH/NYEE) and the BCBS National Network must participate in the Empire PPO plan.** A provider who participates in the Empire PPO plan automatically participates in the EPO as well.

Precertification – When you see the *telephone icon* ✆, you'll know that you or your doctor must precertify these services with Empire's Medical Management Program. The telephone number to precertify is (800) 982-8089. Fourteen (14) days are required for non-emergency precertification. For emergency inpatient hospital admissions or emergency surgical procedures, you or your doctor must pre-certify within 48 hours of the services or as soon as reasonably possible. For inpatient mental health or substance abuse care, you must call the Behavioral Health Program at (800) 626-3643. The penalty for non-precertification of required treatment is 50% of charges up to $2,500 per occurrence.

Empire EPO Medical Coverage Benefits Summary

	You Pay	
	CHP Network (SLR/BI/LICH/NYEE) providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**
Annual Deductible		
Per Individual	None	None
Per Family	None	None
Coinsurance	None	20%
Annual Out-of-Pocket Maximums		
Per Individual	Not applicable	$2,000
Per Family	Not applicable	$4,000
Maximum Lifetime Benefit		
Per Covered Member	Unlimited	Unlimited
Home, Office and Outpatient Care		
Basic Home/Office Visits	$10 co-payment per visit	$30 co-payment per visit
Specialist Visits	$10 co-payment per visit	$30 co-payment per visit
Chiropractic Care	$10 co-payment per visit	$30 co-payment per visit
Second or Third Surgical Opinion ✆	$10 co-payment per visit	$30 co-payment per visit
Diabetes Education and Management	$10 co-payment per visit	$30 co-payment per visit
Allergy Care		
Office Visit	$10 co-payment per visit	$30 co-payment per visit
Testing	$0	$0
Treatment	$0	$0
Diagnostic Procedures		
X-rays	$0	20% coinsurance
MRIs / MRAs ✆	$0	20% coinsurance
PET / CAT Scans ✆	$0	20% coinsurance
Laboratory Tests	$0	$0
Surgery ✆ (For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure.)	$0	20% coinsurance

Empire EPO Medical Coverage Benefits Summary (Continued)

	You Pay	
Home, Office and Outpatient Care (continued)	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**
Outpatient Facility Fees	$0	20% coinsurance
Pre-surgical Testing	$0	20% coinsurance
Anesthesia	$0	20% coinsurance
Chemotherapy, radiation	$0	20% coinsurance
Kidney Dialysis	$0	20% coinsurance
Cardiac Rehabilitation	$10 co-payment per outpatient visit	$30 co-payment per outpatient visit
Preventive Care		
Annual Physical Exam One per calendar year	$0	$30 co-payment per visit
Diagnostic Screening Tests ***Cholesterol: 1 every 2 years*** (except for triglyceride testing)	$0	20% coinsurance
Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years	$0	20% coinsurance
Routine Prostate Specific Antigen (PSA) – Over age 50: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age – Diagnostic PSA: 1 per year	$0	20% coinsurance
Well-woman Care		
Office visits	$0	$30 co-payment per visit
Pap smears	$0	20% coinsurance
Bone density testing and treatment – Ages 55 through 65 – 1 baseline – Age 65 and older – 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) – Under Age 65 – 1 every 2 years (if baseline before age 65 indicates osteoporosis)	$0	20% coinsurance
Mammogram – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year	$0	20% coinsurance

Empire EPO Medical Coverage Benefits Summary (Continued)

Preventive Care (continued)	You Pay: CHP Network (SLR/BI/LICH/NYEE) providers must be Empire BCBS participating	You Pay: BlueCross BlueShield (BCBS) National Network
Well-child Care		
In-hospital visits – Newborn: 2 in-hospital exams at birth	$0	$0
Office visits and associated lab services provided within 5 days of office visit – From birth up to age 1: 7 visits – Ages 1 through 4: 6 visits – Ages 5 through 11: 7 visits – Ages 12 up to 19th birthday: 8 visits	$0	$0
Immunizations	$0	$0
Emergency Care		
Emergency Room	$0	$75 per visit co-payment (waived if admitted to the same hospital within 24 hours)
Physician's Office	$10 co-payment	$30 co-payment
Air Ambulance ✆ Transportation to nearest acute care hospital for emergency in-patient admissions	$0	20% coinsurance
Ambulance Local professional ground ambulance to nearest hospital	$0 up to allowed amount	20% coinsurance
Maternity Care		
Prenatal and Postnatal Care ✆ (in doctor's office)	$0	20% coinsurance
Lab Tests, Sonograms and Other Diagnostic Procedures	$0	20% coinsurance
Routine Newborn Nursery Care (in hospital)	$0	20% coinsurance
Obstetrical Care (in hospital) ✆	$0	20% coinsurance

Empire EPO Medical Coverage Benefits Summary (Continued)

	You Pay	
Reproductive Services	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**
Infertility Treatment Lifetime Maximum Reimbursement	$10,000	$10,000
Advanced Reproductive Technologies (IVF, ZIFT, GIFT, ICSI)	Up to 3 cycles (not to exceed $10,000 lifetime maximum)	20% coinsurance, up to 3 cycles (not to exceed $10,000 lifetime maximum)
Medically Necessary Diagnostic Procedures	$0	20% coinsurance
Pathology and Laboratory Services	$0	20% coinsurance
In-patient Hospital Services		
Semi-private Room and Board	$0	20% coinsurance
Anesthesia Drugs and Oxygen	$0	20% coinsurance
Chemotherapy and Radiation Therapy	$0	20% coinsurance
Diagnostic X-rays and lab Tests	$0	20% coinsurance
Drugs and Dressings	$0	20% coinsurance
General, Special and Critical Nursing Care	$0	20% coinsurance
Intensive Care	$0	20% coinsurance
Kidney Dialysis	$0	20% coinsurance
Services of Licensed Physicians (i.e. Anesthesiologists) and Surgeons	$0	20% coinsurance
Surgery (For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure.)	$0	20% coinsurance
Durable Medical Equipment and Supplies		
Durable Medical Equipment (i.e. hospital-type bed, wheel chair sleep apnea monitor)	$0	20% coinsurance
Orthotics and Prosthetics	$0	20% coinsurance
Medical Supplies (i.e. catheters, oxygen, syringes)	$0	20% coinsurance

Empire EPO Medical Coverage Benefits Summary (Continued)

	You Pay	
Skilled Nursing and Hospice Care	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**
Skilled Nursing Facility ✆ Up to 60 days per calendar year	$0	20% coinsurance
Hospice ✆ Up to 210 days per lifetime	$0	20% coinsurance
Home Health Care		
Home Health Care ✆ Up to 200 visits per calendar year (a visit equals 4 hours of care)	$0	20% coinsurance
Home Infusion Therapy ✆	$0	20% coinsurance
Physical, Occupational, Speech or Vision Therapy		
Physical Therapy and Rehabilitation ✆		
Up to 30 days of in-patient service per calendar year	$0	20% coinsurance
Up to 30 visits combined in home, office or outpatient facility per calendar year	$10 co-payment per visit	$30 co-payment per visit
Occupational, Speech Vision Therapy ✆ Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$10 co-payment per visit	$30 co-payment per visit
Mental Health Care ✆		
Outpatient (in office or facility) ✆ Up to 40 visits per calendar year	$25 co-payment per visit	$25 co-payment per visit
In-patient ✆		
Up to 30 days per calendar year	$0	20% coinsurance
Up to 30 visits from mental health care professionals per calendar year	$0	20% coinsurance
Alcohol or Substance Abuse Treatment		
Outpatient ✆ Up to 60 visits per calendar year, including up to 20 visits for family counseling	$0	20% coinsurance
In-patient ✆		
Up to 7 days detoxification per calendar year	$0	20% coinsurance
Up to 30 days rehabilitation per calendar year	$0	20% coinsurance
Prescription Drug Coverage	**Refer to Page 11**	

Empire PPO

The Empire PPO consists of a comprehensive group of facilities and physicians from whom you may receive care, and provides you with coverage for eligible services outside of the Empire PPO network. The Empire PPO is administered by Empire BlueCross BlueShield (Empire BCBS) and has two coverage networks. The primary network consists of any Empire PPO participating provider or facility affiliated with SLR, BI, LICH or NYEE. The secondary network consists of any of the other providers in BlueCross BlueShield's extensive national network. There is also out-of-network coverage if you use a non-BCBS participating facility or physician.

In-network coverage – If you use a SLR, BI, LICH or NYEE Empire BCBS participating provider (CHP Network), there is a $15 co-payment for physician basic office visits. If you use a BCBS participating provider **not** affiliated with SLR, BI, LICH, or NYEE (BCBS National Network), there is a $30 co-payment for physician basic office visits. You pay 10% coinsurance for other eligible physician office services.

If you are traveling or live outside of the Empire PPO service area, you may still take advantage of the plan's benefits by calling (800) 810-BLUE or (800) 992-BLUE. A service representative will direct you to a local physician or facility and you will receive Empire PPO benefits. When you receive care from any BCBS participating provider, your physician will submit your claim form to Empire for reimbursement. Be sure to confirm that your provider participates in the Empire PPO in order to receive maximum benefits. For provider information, you may call the Empire Dedicated Center at (800) 741-0086.

Out-of-network coverage – You have the option to seek care from any provider or facility outside of the CHP network or the larger BCBS National Network. If you receive care from a provider or at a facility that is not part of either network, eligible services are covered at 70% of reasonable and customary (R&C) charges, after you meet an annual deductible.

Air ambulance coverage – This benefit covers emergency air ambulance transport to the nearest acute care facility when ground transportation is not available. To ensure full coverage, Empire's Medical Management department must authorize in advance, when feasible, or within 48 hours after admission the use of an air ambulance. The following conditions must be met:

- A covered person's medical condition requires immediate and rapid ambulance transportation and services cannot be provided by land ambulance due to great distances or other geographic obstacles, and the use of land transportation would pose immediate threat to the covered person's health.
- Services will be covered for an air ambulance used to transport a covered person from one acute care hospital to another, only if the transferring hospital does not have adequate facilities to provide the medically necessary services needed for the covered person's treatment as determined by Empire, and use of a land ambulance would pose an immediate threat to the covered person's health.

Mental Health coverage. In-network mental health and substance abuse services is provided through the Behavioral Health Program. Coverage is also provided for out-of-network mental health and substance abuse providers.

In order to receive coverage for in-patient and outpatient mental health or substance abuse care provided in-network, you must obtain authorization in advance by calling the Behavioral Health Program at (800) 626-3643. You will be sent a written confirmation of the authorized services. You must also call the Behavioral Health Program in advance of in-patient mental health or substance abuse care provided out-of-network. Precertification is not required for outpatient out-of-network mental health or substance abuse care.

Empire PPO Medical Plan Benefits Summary

Following is a brief overview of your coverage. **Providers in both the CHP Network (SLR/BI/LICH/NYE&E) and the Empire BCBS Network must participate in the Empire PPO plan.** For eligible out-of-network services, reimbursement is based on reasonable and customary (R&C) charges. Charges in excess of R&C are not covered by the plan.

Precertification – When you see the *telephone icon* ✆, you'll know that you or your doctor must precertify these services with Empire's Medical Management Program. The telephone number to precertify is (800) 982-8089. Fourteen (14) days are required for non-emergency precertification. For emergency inpatient hospital admissions or emergency surgical procedures, you or your doctor must pre-certify within 48 hours of the services or as soon as reasonably possible. For inpatient mental health or substance abuse care, you must call the Behavioral Health Program at (800) 626-3643. The penalty for non-pre-certification of required treatment is 50% of charges up to $2,500 per occurrence.

Empire PPO Medical Plan Benefits Summary

	You Pay		
	CHP Network (SLR/BI/LICH/NYEE) providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**	**Out-of-Network** (Charges in escess of R&C are not considered by the plan.)
Annual Deductible			
Per Individual	None	None	$1,000
Per Family	None	None	$2,500
Coinsurance	10%	10%	30%
Annual Out-of-Pocket Maximums			
Per Individual	$2,000	$2,000	$4,500 (Including deductible)
Per Family	$4,000	$4,000	$11,250 (Including deductible)
Maximum Lifetime Benefit			
Per Covered Member	Unlimited	Unlimited	$1,000,000
Home, Office and Outpatient Care			
Basic Home/Office Visits	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Specialist Visits	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Chiropractic Care	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Second or Third Surgical Opinion	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Diabetes Education and Management	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Allergy Care			
Office Visit	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Testing	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Treatment	$0	10% coinsurance	Deductible & 30% coinsurance
Diagnostic Procedures			
X-rays	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
MRIs / MRAs	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
PET / CAT Scans	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Laboratory Tests	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance

Empire PPO Medical Plan Benefits Summary (Continued)

	You Pay		
Home, Office and Outpatient Care (continued)	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**	**Out-of-Network** (Charges in escess of R&C are not considered by the plan.)
Surgery ✆ (For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure.)	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Outpatient Facility Fees	10% coinsurance	$100 co-payment & 10% coinsurance	Deductible & 30% coinsurance
Pre-surgical Testing	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Anesthesia	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Chemotherapy, radiation	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Kidney Dialysis	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Cardiac Rehabilitation ✆	$15 co-payment per outpatient visit	$30 co-payment per outpatient visit	Deductible & 30% coinsurance
Preventive Care			
Annual Physical Exam One per calendar year	$15 co-payment per visit	$30 co-payment per visit	Not covered
Diagnostic Screening Tests ***Cholesterol: 1 every 2 years*** (except for triglyceride testing)	$0	10% coinsurance	Deductible & 30% coinsurance
Colorectal cancer – Fecal occult blood test if age 40 or over: 1 per year – Sigmoidoscopy if age 40 or over: 1 every 2 years	$0	10% coinsurance	Deductible & 30% coinsurance
Routine Prostate Specific Antigen (PSA) – Over age 50: 1 every year – Between ages 40-49 if risk factors exist: 1 per year – If prior history of prostate cancer, PSA at any age – Diagnostic PSA: 1 per year	$0	10% coinsurance	Deductible & 30% coinsurance

Empire PPO Medical Plan Benefits Summary (Continued)

Preventive Care (continued)	You Pay **CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**	**Out-of-Network** (Charges in escess of R&C are not considered by the plan.)
Well-woman Care			
Office visits	$15 co-payment per visit	$30 co-payment per visit	Deductible & 30% coinsurance
Pap smears	$0	10% coinsurance	Deductible & 30% coinsurance
Bone density testing and treatment – Ages 55 through 65 – 1 baseline – Age 65 and older – 1 every 2 years (if baseline before age 65 does not indicate osteoporosis) – Under Age 65 – 1 every 2 years (if baseline before age 65 indicates osteoporosis)	$0	10% coinsurance	Deductible & 30% coinsurance
Mammogram – Ages 35 through 39 – 1 baseline – Age 40 and older – 1 per year	$0	10% coinsurance	Deductible & 30% coinsurance
Well-child Care			
In-hospital visits – Newborn: 2 in-hospital exams at birth	$0	$0	Deductible & 30% coinsurance
Office visits and associated lab services provided within 5 days of office visit – From birth up to age 1: 7 visits – Ages 1 through 4: 6 visits – Ages 5 through 11: 7 visits – Ages 12 up to 19th birthday: 8 visits	$0	$0	Deductible & 30% coinsurance
Immunizations	$0	$0	Deductible & 30% coinsurance
Emergency Care			
Emergency Room	$0	$75 (waived if admitted within 24 hours)	$75 (waived if admitted within 24 hours)
Physician's Office	$0	$30 co-payment	Deductible & 30% coinsurance
Ambulance Local professional ground ambulance to nearest hospital	10% coinsurance	10% coinsurance	Subject to in-network benefits
Air Ambulance ✆ Transportation to nearest acute care hospital for emergency IN-PATIENT admissions	10% coinsurance	10% coinsurance	You pay the difference between the allowed amount and the total charge

Empire PPO Medical Plan Benefits Summary (Continued)

	You Pay		
Maternity Care	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**	**Out-of-Network** (Charges in escess of R&C are not considered by the plan.)
Prenatal and Postnatal Care ✆	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Lab Tests, Sonograms and Other Diagnostic Procedures	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Routine Newborn Nursery Care (in hospital)	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Obstetrical Care (in hospital) ✆	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Reproductive Services			
Infertility Treatment Lifetime Maximum Reimbursement	$10,000	$10,000	Not covered
Advanced Reproductive Technologies ✆ (IVF, ZIFT, GIFT, ICSI)	10% coinsurance Up to 3 cycles (not to exceed $10,000 lifetime maximum)	10% coinsurance Up to 3 cycles (not to exceed $10,000 lifetime maximum)	Not covered
Medically Necessary Diagnostic Procedures ✆	10% coinsurance	10% coinsurance	Not covered
Pathology and Laboratory Services ✆	10% coinsurance	10% coinsurance	Not covered
In-patient Hospital Facility and Ancillary Services			
Semi-private Room and Board ✆	$0	$250 co-payment & 10% coinsurance per admittance	Deductible & 30% coinsurance
Anesthesia Drugs and Oxygen	$0	10% coinsurance	Deductible & 30% coinsurance
Chemotherapy and Radiation Therapy	$0	10% coinsurance	Deductible & 30% coinsurance
Diagnostic X-rays and Lab Tests	$0	10% coinsurance	Deductible & 30% coinsurance
Drugs and Dressings	$0	10% coinsurance	Deductible & 30% coinsurance
General, Special and Critical Nursing Care	$0	10% coinsurance	Deductible & 30% coinsurance
Intensive Care ✆	$0	10% coinsurance	Deductible & 30% coinsurance
Kidney Dialysis	$0	10% coinsurance	Deductible & 30% coinsurance

Empire PPO Medical Plan Benefits Summary (Continued)

	You Pay		
Other In-patient Hospital Services	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**	**Out-of-Network** (Charges in escess of R&C are not considered by the plan.)
Services of Licensed Physicians (i.e. Anesthesiologists) and Surgeons	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Surgery ✆ (For a second procedure performed during an authorized surgery through the same incision, Empire pays for the procedure with the higher allowed amount. For a second procedure done through a separate incision, Empire will pay the allowed amount for the procedure with the higher allowance and up to 50% of the allowed amount for the other procedure.)	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Durable Medical Equipment and Supplies			
Durable Medical Equipment ✆ (i.e. hospital-type bed, wheel chair sleep apnea monitor)	10% coinsurance	10% coinsurance	Not covered
Orthotics and Prosthetics ✆	10% coinsurance	10% coinsurance	Not covered
Medical Supplies (i.e. catheters, oxygen, syringes)	10% coinsurance	10% coinsurance	Difference between the allowed amount and the total charge (deductible and coinsurance do not apply)
Skilled Nursing and Hospice Care			
Skilled Nursing Facility ✆ Up to 60 days per calendar year	10% coinsurance	10% coinsurance	Not covered
Hospice ✆ Up to 210 days per lifetime	10% coinsurance	10% coinsurance	Not covered
Home Health Care			
Home Health Care ✆ Up to 200 visits per calendar year (a visit equals 4 hours of care)	10% coinsurance	10% coinsurance	30% coinsurance only No deductible
Home Infusion Therapy ✆	10% coinsurance	10% coinsurance	Not covered

Empire PPO Medical Plan Benefits Summary (Continued)

	You Pay		
Physical, Occupational, Speech or Vision Therapy	**CHP Network (SLR/BI/LICH/NYEE)** providers must be Empire BCBS participating	**BlueCross BlueShield (BCBS) National Network**	**Out-of-Network** (Charges in escess of R&C are not considered by the plan.)
Physical Therapy and Rehabilitation			
Up to 30 days of in-patient service per calendar year	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
Up to 30 visits combined in home, office or outpatient facility per calendar year	$15 co-payment per visit	$30 co-payment per visit	Not covered
Occupational, Speech Vision Therapy Up to 30 visits per person combined in home, office or outpatient facility per calendar year	$15 co-payment per visit	$30 co-payment per visit	Not covered
Mental Health Care			
Outpatient (in office or facility) Up to 40 visits per calendar year (Treatment maximums are combined for in-network and out-of-network care)	$25 co-payment per visit	$25 co-payment per visit	Deductible & 50% coinsurance
In-patient Up to 30 days per calendar year Up to 30 visits from mental health care professionals per calendar year (Treatment maximums are combined for in-network and out-of-network care)	10% coinsurance	10% coinsurance	Deductible & 50% coinsurance
Alcohol or Substance Abuse Treatment			
Outpatient Up to 60 visits per calendar year, including up to 20 visits for family counseling	10% coinsurance	10% coinsurance	Deductible & 30% coinsurance
In-patient Up to 7 days detoxification per calendar year Up to 30 days rehabilitation per calendar year (Treatment maximums are combined for in-network and out-of-network care)	10% coinsurance	10% coinsurance	Deductible & 50% coinsurance
Prescription Drug Coverage	**Refer to Page 11**		

Coordination of Benefits (COB)

Empire has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one health plan. The benefits provided by Empire will be coordinated with any benefits you are eligible to receive under the other plan. Together, the plans will pay up to the amount of covered expenses, but not more than the amount of actual expenses. When you are covered under two plans, one plan has primary responsibility to pay benefits and the other has secondary responsibility. The plan with primary responsibility pays benefits first.

Which Plan Pays Benefits First?

Here is how Empire determines which plan has primary responsibility for paying benefits:

- If the other health plan does not have a coordination of benefits feature, that plan is primary.
- If you are covered as an employee under the Empire plan and as a dependent under the other plan, your Empire plan is primary.
- For a dependent child covered under both parents' plans, the primary plan is:
  - The plan of the parent whose birthday comes earlier in the calendar year (month and day)
  - The plan that has covered the parent for a longer period of time, if the parents have the same birthday
  - The father's plan, if the other plan does not follow the "birthday rule" and uses gender to determine primary responsibility
  - If the parents are divorced or separated (and there is no court decree establishing financial responsibility for the child's healthcare expenses), the plan covering the parent with custody is primary.
  - If the parent with custody is remarried, his or her plan pays first, the stepparent's plan pays second and the non-custodial parent's plan pays third.
  - If the parents are divorced or separated and there is a court decree specifying which parent has financial responsibility for the child's healthcare expenses, that parent's plan is primary, once the plan knows about the decree.
- If you are actively employed, your plan is primary in relation to a plan for laid-off or retired employees.
- If none of these rules apply, the plan that has covered the patient longest is primary.

If Empire Is the Secondary Plan

If the Empire plan is secondary, then benefits will be reduced so the total benefits paid by both plans will not be greater than the allowable expenses. Also, Empire will not pay more than the amount Empire would normally pay if Empire were primary.

Tips for Coordinating Benefits

- To receive all the benefits available to you, file your claim under each plan.
- File claims first with the primary plan, then with the secondary plan.
- Include the original or a copy of the Explanation of Benefits (EOB) from the primary plan when you submit your bill to the secondary plan. Remember to keep a copy for your records.

Point of Service Plan

A Point of Service (POS) plan requires you to select a primary care physician (PCP) from a list of providers who have agreed to offer care under the terms of the POS plan. Your PCP is responsible for managing your medical care needs and referring you to participating specialists or facilities. Women may receive gynecological exams from a network OB/GYN without a PCP referral. You need to list both your OB/GYN and your PCP with your carrier. You need to inform the carrier of any change.

Each time you seek care, you decide how you wish to use the plan. If you receive care or a referral from your PCP, you will pay a small co-payment for most services. Deductibles and out-of-pocket maximums do not apply and you do not have to submit claim forms. If you do not receive care or a referral from your PCP – even if you see a network physician – you will be reimbursed for a percentage of your costs after satisfying an annual deductible. Out-of-pocket maximums apply and you are responsible for filing claim forms.

*HIP 70% POS**

Listed below are highlights of the HIP 70% POS plan:

- The annual deductible for out-of-network services is $500 per individual up to $1,000 per family.
- The annual out-of-pocket maximum (including deductible) is $4,000 per individual and $8,000 per family.

Long Island College Hospital and DOCS are excluded from this option.

* *Percentage refers to the coinsurance reimbursement level for out-of-network care.*

HIP 70% POS Medical Plan – Benefit Summary (for BI/SLR only)

	In-Network[1]	Out-of-Network[2]
Annual Deductible		
Major Medical & Outpatient		
Per Individual	None	$500
Per Family	None	$1,000
Coinsurance	None	30%
Annual Out of Pocket Maximum		
Major Medical & Outpatient		
Per Individual	None	$4,000
Per Family	None	$8,000
Coinsurance	None	30%
Preventive Care		
Physical Examination	$10 copay	Not covered
Routine pediatric care	100%	Pediatric preventive care **through** age 19: 70% after deductible
Immunizations	$10 copay	Pediatric preventive care **through** age 19: 70% after deductible
Well Woman Care (Including pap smears and mammograms)	$10 copay	70% after deductible

HIP 70% POS Medical Plan – Benefit Summary (Continued)

	In-Network[1]	Out-of-Network[2]
Outpatient Care		
Physician office visits	$10 copay	70% after deductible
Surgery	100%	70% after deductible
Laboratory services	100%	70% after deductible
Magnetic Resonance Imaging (MRI)[3]	100%	70% after deductible
Allergy Care		
Initial visit, and all subsequent referral visits	$10 copay per visit	70% after deductible
Hospital Care		
Physician's and surgeon's services	100%	70% after deductible
Semi-private room and board	$500 copay per continuous confinement. Waived at SLR/BI/LICH/NYEE	70% after deductible
All drugs and medication	100%	70% after deductible
Private Duty Nursing	Not Covered	Not Covered
Emergency Care ***(HIP must be contacted within 48 hours)***		
Ambulance service when Medically Necessary	100%	70% after deductible
Emergency Care in Urgi-Center	$10 copay per visit	70% after deductible
Maternity		
Prenatal and post-natal care	100%	70% after deductible
Hospital services for mother and child	$500 copay per continuous confinement. Waived at SLR/BI/LICH/NYEE	70% after deductible
Short Term Rehabilitation[3]		
90 outpatient visits per condition/lifetime	$10 copay per visit	70% after deductible
Home Health Care		
100 home care visits	100%	70% after deductible
Physician house calls	Not covered	70% after deductible
Skilled Nursing Facility		
30 days per calendar year	100%	Not covered
Substance Abuse[3]		
7 days of inpatient detoxification per calendar year	$500 copay per continuous confinement. Waived at SLR/BI/LICH/NYEE	Not covered
30 days of inpatient rehabilitation per calendar year	$500 copay per continuous confinement. Waived at SLR/BI/LICH/NYEE	Not covered
60 outpatient rehabilitation visits per calendar year	$10 per visit	Not covered

Note: **30 days of inpatient treatment for Substance Abuse/Alcohol and Substance Abuse is a combined maximum**.

HIP 70% POS Medical Plan – Benefit Summary (Continued)

	In-Network[1]	Out-of-Network[2]
Mental Health Care[3]		
30 days of inpatient care per calendar year	$500 copay per continuous confinement Waived at SLR/BI/LICH/NYEE	70% after deductible
20 outpatient visits per calendar year	$10 copay per visit	50% after deductible
Retail Prescription Drugs		
Per prescription (Generic)	$5 copay	$5 copay
Per prescription (Brand)	$10 copay	$10 copay
Mail Order Prescription Drugs		
Per prescription (Generic)	$2.50 copay	Not covered
Per prescription (Brand)	$5 copay	Not covered
Chiropractic Care		
Chiropractic Care	$10 copay per visit	70% after deductible
Hospice Care (210 days)		
Inpatient Care	100%	Not covered
Outpatient Care	100%	Not covered
Dental Coverage		
General Dental Care	Covered at reduced fee schedule	Not covered
Preventive Care (Oral Exam, once every 6 months)	$5 copay per visit	Not covered
Cleaning (Once every 6 months)	$10 copay per visit	Not covered
Fluoride	$10 copay per visit	Not covered
Eye Care		
Eye Exam	100% for refractive	70% after deductible
Eye Glasses	$45 for a complete pair every 24 months at participating providers	Not covered
Hearing Coverage		
Hearing Aids	Not Covered	Not covered
Cochlea Implants	100%	Not covered
Other Coverage		
Durable Equipment, when Medically Necessary	$100 annual deductible	Not covered
Diabetes Equipment, Supplies and Education	$10 copay	70% after deductible

Notes:

1 *You must select a PCP from a list of providers who have agreed to offer care under the terms of your Point of Service Plan. Women may receive gynecological exams from a network OB/GYN without a PCP referral. For a list of participating physicians, you may visit the website (www.hipusa.com). You should note that our plan is the Prime POS plan.*

2 *Out-of-network reimbursement percentage is based on reasonable and customary charges (R&C) and apply to all plan features. Charges in excess of R&C are not covered by the plan.*

3 *4 days required for non-emergency precertification. The penalty for non-precertification of required treatment is 50% of charges (no annual or per occurrence dollar limit). It is important to call to determine whether a recommended treatment or therapy is subject to precertification. The telephone number to precertify is (800) 447-8255. Some of the procedures, which require precertification are:*

- *Mental Health and Substance Abuse*
- *MRI*
- *Physical Therapy*
- *Occupational Therapy*
- *Speech Therapy*
- *Vision Therapy*

Penalty for Non-Precertification for Each of the Plans Offered

Empire PPO and Empire EPO

- The penalty for non-precertification of required treatments is 50% of charges up to $2,500 per occurrence.

HIP 70% POS

- The penalty for non-precertification of required treatments is 50% of charges with no annual or per occurrence maximum.

Post-Mastectomy Surgery Mandate

Federal law has been enacted (the Omnibus Consolidated and Emergency Supplemental Appropriations Act) which contains a mandate for group health plans that provide medical and surgical benefits for a mastectomy. The law requires that such plans provide the following benefits:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Plans may not penalize or give incentives to providers to provide care in a manner inconsistent with the reconstructive surgery requirement. Usual plan deductibles and coinsurance will apply.

Maternity Coverage

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 from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Understanding Reasonable And Customary Charges

Each plan's out-of-network reimbursement is based on the reasonable and customary (R&C) amount. R&C is determined by taking into account what the majority of doctors in your geographic area charge for specific services. For instance, if most of the doctors in your area charge $75 for an office visit, then $75 is considered reasonable and customary.

The Dental / Vision / Hearing Plan

There are two dental plan options available. Regardless of which dental option you select, you will have the same vision and hearing benefits. The two dental options are the Guardian DentalGuard Preferred PPO Plan and the Empire Managed Dental Plan. Participation is voluntary, so you may waive coverage if you choose. However, be aware that if you waive coverage, you are waiving coverage for all components of the plan. For instance, you may not waive dental coverage and select vision and hearing coverage.

Guardian DentalGuard Preferred PPO Plan

The Guardian DentalGuard Preferred PPO Plan is a network dental plan with an extensive group of participating dentists. Each time you need care, you have the option to use a participating provider or a nonparticipating provider. If you use a participating provider, benefits are paid at a percentage of a reduced fee that has been negotiated with participating Guardian providers.

You will generally pay less for participating providers' services because participating providers have agreed to the negotiated fees. Nonparticipating providers may charge more than the negotiated fee, which means you may be required to pay more out of your own pocket for services. In addition, if you use a nonparticipating provider, you will pay a higher deductible and benefits will be paid at a lower percentage. (The example below shows how you save money when you use participating providers.) When you use a participating provider, your claims will be filed for you.

You may obtain a list of participating providers on-line at www.glic.com.

An Example

To help you understand how the Guardian DentalGuard Preferred PPO Plan works, the chart below shows how the plan pays benefits for identical services from two different dentists. In this example, Guardian has negotiated a fee of $100 for a particular basic restorative service. If you visit a participating dentist, he or she will charge you the according to the fee schedule, and the plan will pay a percentage of that amount (in this case, 80%). Your out-of-pocket cost is simply the schedule fee ($100) minus the amount the plan pays ($80).

If you visit a nonparticipating dentist, he or she may charge you more than the fee schedule. If a nonparticipating dentist charges $120, the plan will pay benefits at a lower percentage based on the higher charge (50% of $120). In this case, your out-of-pocket cost is the difference between the amount your dentist actually charges ($120) and the amount the plan pays ($60).

Example: How The Guardian DentalGuard Preferred PPO Plan Works

	If you receive care from a participating provider	If you receive care from a nonparticipating provider
Dentist's service fee	$ 100	$ 120
Schedule fee	$ 100	N/A
Plan pays	$ 80 (80% of schedule fee)	$ 60 (50% of schedule fee)
Your out-of-pocket cost	$ 20	$ 60

Covered Dental Services

The following list is a general guide of some of the more common dental services and is not meant to encompass every dental service covered by the plan. Please contact Guardian at (800) 541-7846 for inquiries related to services not listed.

Preventive and Diagnostic Services (Group I)

- Oral Examination (office visit) – limited to one examination in any six consecutive month period.
- Prophylaxis (Cleaning) – limited to one treatment in any six consecutive month period.
- Fluoride Treatment (children under age 14 only) – limited to one treatment in any six consecutive month period.
- Dental Sealants (children under age 16 only) – limited to one treatment in any 36 consecutive month period.
- Complete X-ray Series - limited to once in any 60 consecutive month period.

Basic Services (Group II)

Includes restorative services such as amalgams (fillings), endodontic services such as root canal therapy, periodontic services such as periodontal root planing, gingivectomy and osseous surgery, and oral surgery such asuncomplicated non-surgical extractions and surgical removed of erupted or impacted teeth.

Major Services (Group III)

Includes restorative services such as inlays and crown and posts (covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material) and prosthodontic services such as fixed bridges, bridge abutments and full and partial dentures.

Orthodontic Services (Group IV)

Covers only children who are less than 19 years old when the active appliance is first placed. Includes diagnostic services, treatment plan, fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Pre-treatment Review (Pre-determination)

A pre-treatment review must be done when the expected cost of a proposed course of treatment is $300.00 or more. In this case, the dentist must submit a treatment plan to Guardian before treatment begins. The treatment plan must include

- a list of services to be done, using the American Dental Association nomenclature and codes;
- the cost of each service; and
- the estimated length of treatment.

Dental x-rays and any other supporting information should also be sent to Guardian so they may evaluate the treatment plan. Emergency treatment, oral examinations, dental x-rays, and teeth cleaning that are part of the course of treatment, may be done before the pre-treatment review is made.

Guardian will review the treatment plan and estimate what will be paid. The estimate will be sent to your or your eligible dependent's dentist. If Guardian does not agree with a treatment plan, or if one is not submitted, Guardian has the right to base payments on treatment suited to your or your eligible dependent's condition by accepted standards of dental practice.

A pre-treatment review is not a guarantee of payment. It informs you and dentist, in advance, what the plan would pay for the covered dental services named in the treatment plan. Payment is conditioned on

- the work being done as proposed and while you or your eligible dependent is insured; and
- the deductible and payment limit provisions and all other terms of the plan.

Special Limitations

Penalty for Late Entrants

If you do not elect to participate in Guardian Dental within 30 days from your date of hire or becoming newly eligible (due to an employment status change) you are considered a late entrant. Guardian will not cover charges incurred by a late entrant for:

- Group II services until 6 months from your effective date of plan coverage;
- Group III services until 12 months from your effective date of plan coverage; and
- orthodontic treatment done in the first 24 months from your effective date of plan coverage. However, this limitation will not apply to covered charges due solely to an injury suffered while insured.

Teeth Lost before Being Insured by the Plan

The plan will not pay for a prosthetic device that replaces teeth lost prior to your coverage effective date unless the device that replaces such teeth also replaces one or more natural teeth lost or extracted after your coverage effective date.

Exclusions

The following services are not covered by the plan:

- Oral hygiene, plaque control or diet restriction.
- Adult orthodontic services.
- Precision attachments.
- Treatment that does not meet accepted standards and dental practice.
- Treatment that is experimental in nature.
- Treatment needed due to an on-the-job or job-related injury.
- Treatment for a condition for which benefits are payable by Workers' Compensation or similar laws.
- Appliance or prosthetic devises used to:
  - Change vertical dimension.
  - Restore or maintain occlusion, except to the extent that the plan covers orthodontic treatment.
  - Splint or stabilize teeth for periodontic reasons.
  - Replace tooth structure lost as a result of abrasion or attrition.
  - Treat disturbances of the temporomandibular joint (TMJ).
- Services for cosmetic reasons including but not limited to:
  - Characterizing and personalizing prosthetic devices.
  - Making facings on prosthetic devices for any teeth in back of the second bicuspid.
  - Teeth whitening.
- Replacement of an appliance or prosthetic device with a like appliance or device, unless:
  - It is at least ten (10) years old and can't be made usable.
  - It is damaged while in the covered person's mouth in an injury suffered while insured, and can't be fixed.
- Replacement of a lost, stolen or missing appliance or prosthetic device.
- The making of a spare appliance or device.
- Treatment for which there is no charge made. This usually means treatment furnished by:
  - The covered person's employer, labor union or similar group, in its dental or medical department or clinic.
  - A facility owned or run by any governmental body.
  - Any public program, except Medicaid, paid for or sponsored by any government body.

The Plan will cover treatment when legally obligated.

Special Provisions After Insurance Ends

The plan will pay for the following if all work is finished in the 31 days after your dental insurance terminates:

- a crown, bridge or cast restoration, if the tooth is prepared before the insurance ends;
- any other prosthetic device, if the master impression is made before the insurance ends; and
- root canal treatment, if the pulp chamber is opened before the insurance ends.

Coordination of Benefits (COB)

Guardian has a coordination of benefits (COB) feature that applies when you and members of your family are covered under more than one dental plan. The benefits provided by Guardian will be coordinated with any benefits you are eligible to receive under the other plan. Together, the plans will pay up to the amount of covered expenses, but not more than the amount of actual expenses. The primary plan pay first, ignoring all other plans. The secondary plan takes into consideration the benefits of the primary plan.

If a plan has no coordination provision, it is primary. However, during any claim determination period, when the plan and at least one other plan have coordination provisions, the rules that govern which plan pay first are as follows:

A A plan that covers a person as a member pays first; the plan that covers a person as a dependent pay second;

B Except for dependent children of separated or divorced parents, the following governs which plan pays first when the person is a dependent of a member:

- A plan that covers a dependent of a member whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of a member whose birthday falls later in the calendar years pays second. The member's year of birth is ignored.
- If both parents have the same beday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
- If the other plan does not have a similar provision for dependent children, then (B) will not apply and the other plan's coordination provision will determine the order of benefits.

C For a dependent child of legally separated or divorced parents, the following governs which plan pays first when the person is a dependent of an employee:

- When a court order makes one parent financially responsible for health care expenses of the dependent child, then that parent's plan pays first;
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

D A plan that covers a person as an active employee or as dependent of such employee pays first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second. But, if the other plan does not have a similar provision for such persons, the (D) will not apply.

If rules (A), (B), (C), and (D) do not determine which plan pays first, the plan that has covered the person for a longer time pays first.

Empire Managed Dental Plan

Empire Dental provides managed dental network benefits and offers you and your covered dependents these advantages:

- a broad scope of benefits.
- reduced out-of-pocket expenses
- access to conveniently located, private dental offices.
- no deductibles.
- diagnostic and preventive dentristy at no cost to you.
- no paperwork, claim filing, and waiting for reimbursement.

If you elect coverage under the Empire Managed Dental Plan, you must select a network provider when you enroll. When you receive care you must use this provider. If you receive care from a nonparticipating provider, you will not receive benefits under the plan. To obtain information on the dentists who participate in the plan, call Empire's customer service line at (800) 722-8879.

With managed dental network benefits, your network dentist assumes complete responsibility for determining the treatment course required by you and/or your covered family members. Your network dentist also performs most services at no cost to you.

Benefits Provided

Under this pre-payment program, the covered member does not pay for most dental services covered by this contract but is responsible for laboratory cost for dentures, crowns, bridges and other prostheses as well as co-payment for general anesthesia.

If the affiliated dentist provides a service not covered by this contract, he may charge his usual fee for that service. This fee is the covered member's responsibility.

Types of Covered Dental Services

- **Diagnostic and Preventive** – Services that include routine preventive. Examples include oral examinations, bitewing x-rays, and adult/child prophylaxis (once every 6 months).
- **Basic** – Services include commonly used dental procedures. Examples include amalgam fillings, simple extractions, and root canals.
- **Major** – Services include complex extractions, periodontal treatment, and the provision of prosthetic appliances. Examples include extraction of impacted teeth, gum surgery, crowns, inlays, fixed bridgework, removable dentures, and repairs to bridgework, removable dentures, and repairs to bridgework and dentures.
- **Orthodontic** – Services (i.e., the correction of a handicapping malocclusion) include an initial exam, insertion of appliance, and treatments. Orthodontic benefits are available to all covered adults and dependent children to age 19.

The Following are Some of the Plan Exclusions and Limitations

- Dental services that were not prescribed, arranged, rendered, nor approved by your network dentist, except for a dental emergency occurring more than 50 miles from your network dentist's office;
- Dental services performed by a non-network dentist, unless authorized by both the member's network dentist and Empire Dental;
- Dental services under any government program, federal, state, county, or municipal law, or the laws of the United States, or any state, or political subdivision of it (except Medicaid);

- Dental services under any Worker's Compensation law, mandatory no-fault automobile insurance, or similar legislation, whether the subscriber either claims compensation or receives benefits thereunder;
- Experimental or obsolete dental procedures that are neither of proven benefit or recognized by the dental profession as effective;
- Elective cosmetic treatment;
- Replacement of misplaced bridges, dentures, or other dental appliances;
- Implants or bridges involving implants;
- Treatment of Temporomandibular Joint Syndrome
- Appliances or restoration used solely to increase vertical dimensions;
- Services rendered by a dentist beyond the scope of his/her license;
- Dental services neither considered within the scope of normal, acceptable dental practice nor consistent with the highest ethical dental standards of the dental profession;
- Dental services not listed in your contract or in any rider to your contract;
- Dental services rendered outside the United States of America, its possessions, Canada, and Mexico, even for emergency care;
- A more costly dental procedure when a lower cost alternate treatment with professionally acceptable results can be used. Under these circumstances, we will limit reimbursement to the least costly procedure;
- Replacement of any teeth lost or extracted before benefits became effective. This includes alteration of existing fixed or removable appliances, unless the procedure includes the replacement or removal of at least one diseased and unrestorable natural tooth removed while this contract's benefits were in effect;
- Care rendered in a hospital. Coverage (except emergency care) is for dental care rendered either in your network dentist's office or in a specialist's office by referral from your network dentist. Any cost associated with care rendered in a hospital, in a facility, or by an additional provider will be your responsibility;
- Placement of bone graft or extra-oral substances in the treatment of periodontal disorders;
- Any disease, condition, or injury sustained because of either declared or undeclared war;
- General anesthesia and intravenous sedation in the absence of documented medical need. However, the network providers have agreed to limit the anesthesia costs for you when provided by your network provider. If you elect either general anesthesia or intravenous sedation in the absence of such documentation, which necessitates referral to another dentist or office, no service will be covered and the discounted anesthesia will not apply;
- Prescription and non-prescription drugs medications
- Precious and semi-precious metals;
- Laboratory tests and fees;
- Orthognathic surgery; or
- Appliances and bridgework used solely to splint periodontally involved teeth.

Referrals

Occasionally, you may require the services of a network dentist or specialist other than your designated network dentist. Under these circumstances:

- Your network dentist submits the required documentation to Empire Dental;
- Empire Dental notifies both you and your dentist in writing upon both review and approval of the referral services;
- Your network dentist then provides you with both written authorization for the services and the specialist's name and address; and
- You pay the appropriate co-payment amount for the services rendered.

Your network dentist will also provide emergency referrals when necessary.

Emergency Care

Your network dentist maintains twenty-four hour emergency telephone service seven days a week. In case of a dental emergency (i.e., palliative care to relieve pain, bleeding or swelling), you will receive advice regarding how and where to obtain emergency assistance. If an emergency occurs more than fifty miles from your network dentist's office, you will receive reimbursement (i.e. up to $25) towards the cost of emergency palliative care.

You will not receive any reimbursement, if in Empire's judgment, the emergency care resulted from obvious patient neglect. Also, you will not receive reimbursement for either non-emergency or unauthorized services provided by a non-network physician.

Case Review

If you disagree with the disposition of a case, you may request a review. You, or your duly authorized representative, must make the request in writing within 60 days.

For review of either a dental case or a treatment, forward the request to:

Empire BlueCross BlueShield
Dental Benefits Program
P.O. Box 791
Minneapolis, Minnesota 55440-0791

Be sure to include your current identification number, the claim number, and any pertinent information or comments. Empire will then send you written notification of the decision, explaining the basis for either upholding or modifying the original decision.

Coordination of Benefits (COB)

Refer to COB provisions on page 26.

To help you understand how both dental plans work, refer to the chart below.

Dental Benefits

Plan Features	The Guardian DentalGuard Preferred PPO Plan[1] *in-network*	The Guardian DentalGuard Preferred PPO Plan[1] *out-of-network*	Empire Managed Dental ***only covers participating providers***
Annual Deductible	$50 per person, $150 per family *does not apply to preventive, diagnostic, or orthodontic services*	$150 per person, $450 per family	$50 per person *applies to orthodontic services only*
Annual Benefit Maximum	$1,500 per person	$1,000 per person	Not applicable
Lifetime Orthodontic Maximum	$1,500 per person	$1,000 per person	$1,000 per person
Preventive Services *such as cleanings*	Plan pays 100% with no deductible	Plan pays 80% after the deductible	Plan pays 100% with no deductible
Diagnostic Services *such as routine exams and X-rays*	Plan pays 100% with no deductible	Plan pays 80% after the deductible	Plan pays 100% with no deductible
Basic Restorative and Endodontic Services *such as fillings and root canals*	Plan pays 80% after the deductible	Plan pays 50% after the deductible	Plan pays 100% with no deductible
Oral Surgery *such as tooth extractions*	Plan pays 80% after the deductible	Plan pays 50% after the deductible	Plan pays 100% with no deductible
Periodontal Services *such as scalings, root planings, and gum surgery*	Plan pays 80% after the deductible	Plan pays 50% after the deductible	Plan pays 100% with no deductible
Major Restorative and Prosthodontic Services *such as crowns, fixed bridgework, and removable braces*	Plan pays 50% after the deductible	Plan pays 50% after the deductible	Employee is responsible for laboratory costs
Orthodontic Services *such as braces*	Plan pays 60% with no deductible up to $1,500 per person per lifetime[2]	Plan pays 50% after the deductible up to $1,000 per person per lifetime[2]	Plan pays 50% of reasonable and customary after the deductible up to $1,000 per person per lifetime

1 *All benefits are based on Guardian's fee schedule with participating providers.*
2 *Adult orthodontia is not covered.*

Vision Plan

UnitedHealthcare administers the vision plan. Benefits are available once every 12 months. UnitedHealthcare Vision does not require a member identification card. You have a choice of providers each time you need vision care:

- You may use a provider who is affiliated with UnitedHealthcare to receive network benefits that are the highest level of benefits available.
- You may use a nonparticipating provider who is not affiliated with UnitedHealthcare, and you will receive benefits according to the out-of-network schedule shown below.

When you receive services from a participating provider, you must pay a $10 co-payment for exams and a $10 co-payment for materials (frames and lenses) or covered contacts before the plan pays benefits. Participating providers' eye examinations include:

- Distance and near acuities
- External and internal ocular examinations
- Distance and near refraction evaluation
- Binocular coordination evaluation
- Gross visual field examination
- Tonometry
- Pupillary testing
- Determination of treatment

When you receive services from a non-participating provider (out-of-network), you must send your itemized receipts, with the participant's social security number and patient's name and date of birth to:

UnitedHealthcare
P.O. Box 30978
Salt Lake City, UT 84130

A summary of the benefits available under the plan is shown below. For a list of providers, visit UnitedHealthcare online at www.myuhcvision.com.

Vision Benefits

Your plan provides the following vision care benefits to you and your eligible dependents:

Benefits at a UnitedHealthcare Network Provider	
Comprehensive Vision Exam ($10 copay; once every 12 months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
Materials ($10 copay)	The material copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
Pair of Lenses (for eyeglasses) (once every 12 months) ■ **Standard single vision** ■ **Standard lined bifocal** ■ **Standard lined trifocal** ■ **Standard lenticular**	**Standard scratch-resistant coating and polycarbonate lenses are covered-in-full.** **Lens Options –** Options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount.
Frames (once every 12 months)	Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
Contact Lenses (in lieu of eyeglasses) (once every 12 months)	
■ **Covered-in-full elective contact lenses**	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 4 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UnitedHealthcare's covered-in-full contact lenses may vary by provider.
■ **All other elective contact lenses**	A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of UnitedHealthcare's covered-in-full contacts (materials copay does not apply). Toric, gas-permeable, and bifocal contacts are all example of contacts that are outside of our covered-in-full selection.
■ **Necessary contact lenses***	Covered-in-full (after applicable copay).

(continued on following page)

Vision Benefits

Benefits at a UnitedHealthcare Network Provider *(continued from previous page)*

Refractive Eye Surgery	UnitedHealthcare Vision participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.myuhcvision.com.

Benefits at an Out-of-Network Provider

UnitedHealthcare's Vision Care Plan allows members to receive services from outside UnitedHealthcare's provider network. Members who use such a provider will receive partial reimbursement up to the maximum schedule listed below. (Please note: copays do not appply to the out-of-network reimbursement schedule.)

Service	Reimbursement Schedule
Exam	Up to $ 40
Single Vision	Up to $ 30
Bifocal	Up to $ 45
Trifocal	Up to $ 55
Lenticular	Up to $120
Frame	Up to $ 50
Necessary Contact Lenses	Up to $ 80
Elective Contact Lenses	Up to $ 80

For information regarding how to file an out-of-network claim, please refer to Section 2 of this Administrative Guide.

Accessing Provider Information: Locate a convenient provider

Via Telephone – You may locate a participating provider 24 hours a day, 7 days a week, by calling UnitedHealthcare's 24-hour toll-free number – (800) 839-3242. Following the voice prompts, you enter your work or home ZIP code. The system responds with a list of the names, addresses, and telephone numbers of up to three providers conveniently located to them.

Via the Internet – You may utilize UnitedHealthcare's Internet Provider Locator, 24 hours a day, 7 days a week, to locate a convenient network provider. Simply log on to www. myuhcvision.com, select the provider locator option, and then enter your unique identification number, as well as your ZIP code. You will be supplied a list of convenient providers to select from, including the distance in miles to that provider. Once a participating provider is chosen, you simply call the provider directly to schedule your appointment.

Hearing Plan

Once every 24 months, the hearing plan provides a benefit of $200 toward the purchase of a hearing aid for employees only. You may receive care from any provider, then submit proof of payment to the Benefits Office for reimbursement. Your dependents are not covered under the hearing plan.

Flexible Spending Accounts

The Health Care and Dependent Care Flexible Spending Accounts (FSAs) offer you the opportunity to use pre-tax dollars to pay for eligible expenses, as determined by the IRS.

With both FSAs, a portion of your pay is redirected to your account before federal, Social Security, and, in most cases, state and local taxes are withheld. After you incur an eligible expense, you submit a claim for reimbursement. When you are reimbursed, you receive some or all of the dollars you have set aside, depending on the amount of your expenses and on whether the reimbursement is for a health care or a dependent care expense. You are not taxed on the amount you receive as reimbursement.

Health Care FSA

You may use the Health Care FSA for health care expenses that are not reimbursable through any medical, dental, vision, or hearing plan. You do not have to be covered under the Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, or Long Island College Hospital's benefits plan to claim expenses through this account. You may also use the account to pay for an eligible dependent's qualified health care expenses. An eligible dependent is anyone you claim as a dependent on your federal income tax return.

The account may be used for any health care expense (except health insurance premiums and long term care insurance premiums) the IRS considers tax deductible on your federal income tax return. Keep in mind, however, that you cannot claim an expense reimbursed through the FSA account as a deduction on your income tax return. Examples of eligible Health Care FSA expenses are shown on the chart below.

How Much Can You Contribute?

The minimum you may contribute to the Health Care FSA is $156 per year; the maximum is $3,000 per year.

Health Care FSA

Eligible Health Care Expenses	Ineligible Health Care Expenses
You may use your Health Care FSA for the following expenses: ■ Abortions ■ Acupuncture ■ Alcohol and drug treatments ■ Amounts above reasonable and customary charges ■ Artificial limbs ■ Braille books ■ Childbirth preparation classes ■ Chiropractic expenses ■ Deductibles, coinsurance or co-payments ■ Expenses that are not covered by another health plan ■ Eyeglasses/sunglasses (prescription only) ■ Guide dogs ■ Nursing services ■ Radial Keratomy, RPK or Lasik eye surgery ■ Smoking cessation programs or related drugs ■ Some over-the-counter medicines and drugs ■ Special education ■ Sunscreen/sunblock ■ Weight-loss programs for treatment of diagnoses such as obesity, hypertension, or heart disease	You may **not** use your Health Care FSA for the following expenses: ■ Cosmetic surgery and expenses related to the surgery ■ Electrolysis ■ Expenses reimbursed by a spouse's health care FSA ■ Hair transplants ■ Health club dues ■ Insurance premiums ■ Nutritional supplements ■ Teeth whitening ■ Warranties and service agreements related to medical devices or equipment ■ Weight-loss programs to improve appearance, general health, or sense of well-being

This is a partial list. You can find a complete list of eligible expenses in IRS Publication #502, "Medical and Dental Expenses," available from your local public library, IRS office, or on-line at ***www.irs.gov/publications/p502/index.html.***

Tax-free Reimbursement for Over-the-counter Medicines and Drugs

Health Care FSA reimbursement can include amounts paid by a participant for medicines and/or drugs purchased without a prescription, which are for medical care (as defined under Section 213 (d) of the Internal Revenue Code), and not merely to advance your general good health. Reimbursement will require submission of the following:

- Receipt dated within the plan year
- Name of the medicine and/or drug name on the receipt
- Completed claim form with over-the-counter purchases detailed line by line (claim form to be provided following enrollment)
- The participant's certification that such medicine or drug is for medical care

The tax-free purchase of over-the-counter medicines and drugs represents a significant tax savings for you as a Health Care FSA participant. Below is a list of sample eligible and ineligible expenses for Health Care FSAs:

- Examples of **eligible** over-the-counter medicines and drugs
  - Acne Preparations
  - Asthma Preparations
  - Hemorrhoid Preparations
  - Anesthetics
  - Antihistamines
  - Lice Preparations
  - Antacids
  - Canker Sore Preparations
  - Ophthalmic Preparations
  - Anti-arthritics
  - Cold Medicines
  - Pain Relievers
  - Antibiotics
  - Cold Sore Preparations
  - Psoriasis Agents
  - Antifungals
  - Cough Medicines
  - Smoking Cessation Aids
  - Analgesics
  - Decongestants
  - Wound Care Products
- Examples of **ineligible** over-the-counter medicines and drugs
  - Dietary Supplements
  - Nutritional Supplements
  - Vitamins
  - Homeopathic Medicines
  - Toiletries

Dependent Care FSA

The Dependent Care FSA allows you to use pre-tax dollars for certain expenses you incur to care for your qualified dependents while you are at work. If you are married, your spouse must work, be a full-time student, or be disabled for you to participate in the Dependent Care FSA. In order for expenses to be considered eligible, your spouse who is not working because of a disability must be incapable of caring for him- or herself. It is not enough that your spouse is able to care for the children or to work; he or she must be incapable of self-care.

Qualified dependents are:

- Your children under age 13 whom you claim as dependents on your federal income tax return
- Other dependents – such as your spouse, an elderly parent, or an older child – provided they are physically or mentally incapacitated, require full-time care, and are claimed as dependents on your federal income tax return

An individual (other than your child under age 19, or your spouse's dependent) may provide care at licensed nursery schools, day camps, or day care centers. Household services are eligible for reimbursement if performed by a provider who is partly responsible for the care of your dependents. **The IRS requires you to provide the name, address, and Social Security or tax identification number of your dependent care provider.**

Indirect Fees in Order to Obtain Dependent Care

Fees and expenses that relate to but are not directly for the care of a dependent, such as application or agency fees, may be employment related if the expenses must be paid in order to obtain care and therefore qualify as eligible Dependent Care FSA expenses. If the dependent care is not ultimately provided, such as forfeiting a deposit to reserve a place in pre-school, then the expenses will not qualify for reimbursement.

Temporary Absenses and Part-time Work

Generally, only eligible expenses for dependent care while you and your spouse are at work are qualified for reimbursement. However short-term absences (such as for a minor illness or vacation) may be disregarded if you must pay for dependent care expenses on a weekly or longer basis. If you work part-time and are required to pay for dependent care expenses on a weekly or longer basis, then you are not required to allocate expenses between days worked and days not worked.

How Much Can You Contribute? The minimum you may contribute to the Dependent Care FSA is $156 per year. The annual maximum is:

- $5,000 if you are single, or you are married and file a joint tax return
- $2,500 if you are married, and you and your spouse file separate tax returns

The amount of the lower-paid spouse's income if you or your spouse earns less than $5,000 annually

Federal Tax Credit. You can take a tax credit on your federal income tax return, ranging from 20% to 30% of your eligible dependent care expenses, depending on your adjusted gross income. If you do so, you may claim up to $2,400 of eligible expenses on your federal tax return if you have one dependent, or up to $4,800 if you have two or more dependents. You may not, however, claim the same expense in both places. In fact, the money you redirect to your Dependent Care FSA will reduce the federal tax credit available to you on a dollar-for-dollar basis. We cannot provide you with tax advice, therefore you should direct questions about your own tax situation to your personal tax advisor.

Dependent Care FSA

Eligible Dependent Care Expenses	Ineligible Dependent Care Expenses
You may use your Dependent Care FSA for the following expenses: ■ Care provided in your home by a baby-sitter, housekeeper, or relative who is not a dependent under age 19 ■ Licensed care provided outside your home, including qualified day care, day camp, or preschool, or services such as before- or after-school programs ■ Elder day care ■ Transportation costs charged by a dependent care provider	You may **not** use your Dependent Care FSA for the following expenses: ■ Kindergarten ■ Overnight camp ■ Activity fees ■ Child support payments ■ Cleaning and cooking services not provided by the caregiver ■ Educational supplies ■ Expenses reimbursed by a spouse's dependent care FSA ■ Food, clothing, or entertainment for a baby-sitter in or out of your home ■ Late-payment fees

This is a partial list. You can find a complete list of eligible expenses in IRS Publication #503, "Child and Dependent Care Expenses," available from your local public library or IRS office.

Grace Period Health Care FSA and Dependent Care FSA

The Grace Period gives you an opportunity to minimize your chance of forfeiting funds ("use it or lose it" rule) from your Health Care FSA and Dependent Care FSA. You have an additional 75 days after the end of the plan year to incur claims and make sure you empty out your prior plan year's Health Care FSA and Dependent Care FSA balances.

What is the Grace Period?

- The Grace Period is an additional period of time during which you may incur eligible expenses that can be reimbursed from your Health Care FSA and Dependent Care FSA.
- The Grace Period runs through March 15 following the end of the prior plan year.
- During the Grace Period, you may submit expenses incurred during the prior plan year or during the Grace Period (January 1 - March 15).
- You will initially be reimbursed for eligible expenses based on when they were incurred – expenses incurred during the prior plan year will be reimbursed based on your prior plan year balance, and expenses incurred during the Grace Period will be reimbursed based on your new plan year election/balance.
- After the run-out period for the prior plan year, any expenses incurred during the Grace Period will be reallocated to reduce any remaining balance in your prior plan year account.

Who is eligible to take advantage of the Grace Period?

You may take advantage of the Grace Period only if you participate in a Health Care FSA and/or a Dependent Care FSA in the current plan year. For example, in order to take advantage of the Grace Period, you must have been enrolled in a 2006 Health Care FSA and/or Dependent Care FSA and be currently enrolled in a 2007 Health Care FSA and/or Dependent Care FSA.

Are there times when the Grace Period will not apply?

The grace period will not apply if you terminate employment during the year. If you terminate during the year you may only seek reimbursement for expenses you incur through the date of your termination.

Effect on Other Benefits

The pre-tax amounts you redirect to your FSA accounts will not affect your other salary-based benefits (life insurance, disability insurance, and pension). That is, your other salary-based benefits are based on your salary before amounts are redirected to your FSA accounts.

If you enroll in one or both FSAs and your annual salary is below the Social Security Wage Base (the maximum pay against which Social Security taxes can be withheld), your current Social Security taxes will be lower. Your future Social Security retirement benefits may also be slightly lower. Individual taxes differ and you should discuss any questions with your tax advisor.

Important Information About Flexible Spending Accounts

As a result of the tax advantages offered by FSAs, the IRS has established rules about the contributions that you direct into your accounts. These rules are as follows:

- Any money you put into the Health Care FSA or Dependent Care FSA must be used for reimbursement of expenses incurred during the same year you directed the money to your FSA or through the Grace Period, if applicable (refer to page 40), and for the purposes of your initial enrollment, for expenses incurred after you become a participant.
- **To be reimbursed, you must submit your claims for expenses incurred during the current year by March 31 of the following year. Any FSA money that remains unclaimed after March 31 will be forfeited. For terminated employees, you have 90 days from your employment termination date to submit eligible expenses that were incurred prior to your termination date. Expenses received after the 90-day period will not be considered.**
- Unless you have a qualified family status change as defined by the Internal Revenue Service (see page 9 of this enrollment guide) you cannot change your FSA selection until the next plan year.
- You may not use the Health Care FSA to pay dependent care expenses, or vice versa.
- Health Care FSA – The IRS rules state that the services must be received at the same time that you are contributing. Therefore, if you terminate, only care provided while actively employed would be considered except when the Health Care Flexible Spending Account is continued under COBRA.
- Dependent Care FSA – The IRS rules state that the services must be received at the same time that you are contributing. Therefore, if you terminate, only care provided while actively employed would be considered.

The Life Insurance Plan

Basic Life Insurance

The Life Insurance Plan provides you with Basic Life Insurance coverage equal to one times your annual base salary (rounded up to the next $1,000), to a maximum of $500,000. This is employer provided coverage and you do not contribute towards the cost of this insurance. Annual base salary means your total annual base compensation. This does not include overtime, bonuses, or any other special form of compensation you may receive during the year.

Additional Life Insurance

You may add to your Basic Life Insurance benefit on a contributory basis. The cost to enroll in the additional life insurance options is based on your age and base salary and will be available to you when you enroll on-line.

- You may elect Additional Life Insurance equal to one, two, three, four, or five times your annual base salary up to $750,000. Your benefit will be rounded to the next $1,000. The combined maximum for Basic Life and Additional Life coverage is $1,250,000.

Dependent Life Insurance

You may enroll in Dependent Life Insurance plans on a contributory basis. The cost for Spouse Life Insurance is based on your spouse's age and the amount of coverage you elect. Costs for Dependent Life Insurance plans will be available to you when you enroll on-line.

- You may elect *Spouse Life Insurance* in the amounts of $5,000, $10,000, $15,000, or $20,000 and/or *Child Life Insurance* in the amount of $4,000 for each of your children up to age 19, or up to age 25 if full-time students and wholly dependent on you for maintenance and support.
- Dependent Life Insurance is not available to domestic partners or their children. Child Life Insurance is not available to LICH employees.

Life Insurance Coverage Exclusions

Your plan does not cover any losses where death is caused by, contributed to, or results from:

- suicide occurring within 24 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium. The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and the life insurance carrier approves the evidence of insurability form and the amount you or your dependent applied for at that time.

Accidental Death & Dismemberment Insurance

You may enroll in the Accidental Death & Dismemberment (AD&D) plan on a contributory basis. The cost is based on your annual base salary and is shown on our enrollment worksheet when you enroll on-line.

- AD&D is equal to two times your annual base salary rounded to the next $1,000 to a maximum benefit of $500,000. This plan pays a benefit if you die, become dismembered, or lose your eyesight, speech or hearing as the result of an accident. The amount of the benefit is determined by your loss.

Accidental Death & Dismemberment (AD&D) Benefits

Loss	Insurance Coverage
Life	100%
Both hands or both feet or sight of both eyes	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
Speech and Hearing in both ears	100%
Quadriplegia (Total and irreversible paralysis of all four limbs)	100%
Paraplegia (Total and irreversible paralysis of both lower limbs)	75%
Speech or Hearing	50%
Sight of one eye	50%
Either hand or foot	50%
Hemiplegia (Total and irreversible paralysis of one arm and one leg on the same side of the body)	50%
Thumb and index finger of same hand	25%

Additional AD&D Benefits

- If you were wearing a seat belt during the accident, additional 10% benefit up to $10,000.
- If in a car equipped with an airbag during the accident, additional 10% benefit up to $10,000.
- Return of remains if you die outside of a 150 mile radius of your home, the lesser of $2,500 or actual expense.

A Word About Beneficiaries

If you die while covered by the plan, benefits are payable to your beneficiary. You must name a beneficiary for your life insurance coverage – Basic Life, Additional Life or Accidental Death & Dismemberment. You may designate anyone you wish as your beneficiary, or change your beneficiary designation at any time. You may also designate more than one beneficiary. You are automatically the beneficiary of any Dependent Life Insurance coverage you purchase.

If your designated beneficiary does not survive you, your life insurance benefits will be payable in the order shown below.

Any amount of insurance for which there is no beneficiary at your death will be payable to the first of the folllowing: your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

When Your Salary Changes

The amount of your Basic Life, Additional Life and AD&D coverage will change on the date your annual base salary changes.

Evidence of Insurability (EOI) Requirements

Open Enrollment

The evidence of insurability rules are as follows during the open enrollment period only:

- If you currently have the $50,000 Basic Life option, evidence of insurability will be required if you elect the one times salary Basic Life option.
- If you currently have no Additional Life Insurance coverage, evidence of insurability will be required if you elect any level of Additional Life Insurance.
- If you currently have one or two times salary in Additional Life Insurance coverage, you may increase your coverage by one level without providing evidence of insurability. Increases in higher increments will require evidence of insurability. Evidence of insurability will be required if the combined amount of your Basic and Additional Life Insurance coverage exceeds $750,000 **or** if you purchase four or five times your base annual salary.
- If you currently have no AD&D Insurance and elect AD&D coverage, evidence of insurability will not be required.

- If you currently have no Spouse Life Insurance coverage and elect any level of coverage, evidence of insurability will be required.
- If you currently have $5,000, $10,000, or $15,000 in Spouse Life Insurance coverage, you may increase your coverage by one level without providing evidence of insurability. Increases in higher amounts will require evidence of insurability.
- If you currently have no Child Life Insurance coverage for your child(ren), you may elect $4,000 in coverage for each child without providing evidence of insurability.

Evidence of Insurability forms may be obtained from the Benefits Office at 555 West 57th St. 19th Floor, New York, NY 10019.

Family Status Changes

If you have a qualifying family status change, as defined on page 9, and notify the Benefits Office within 30 days of the event, you may make the following benefit changes *without* evidence of insurability:

- Increase your Basic Life Insurance coverage option from $50,000 to 1x base pay.
- Change your Additional Life Insurance option from no coverage (waive) to 1x additional base pay.
- Increase your Additional Life Insurance coverage option by one level (increases by more than one level, i.e. 1x base pay to 3x base pay, will require satisfactory evidence of insurability.)
- Change your Spouse Life Insurance option from no coverage (waive) to any level of coverage if the change is due to marriage.
- Change your Child Life Insurance option from no coverage (waive) to the $4,000 coverage option if the change is due to birth.

New Hires

If you are a newly hired employee, evidence of insurability is required for Additional Life coverage if the combined amount of your Basic and Additional life insurance exceeds $750,000 OR if you purchase four times or five times your base annual salary. Basic Life, Accidental Death and Dismemberment and Dependent Life Insurance coverage do not require evidence of insurability. You must apply within the first 30 days of your date of hire.

Evidence of Insurability forms may be obtained from the Benefits Office at 555 West 57th St. 19th Floor, New York, NY 10019.

Understanding Imputed Income

The value of any Basic Life Insurance coverage over $50,000 is considered "imputed income." Any imputed income will be reflected on your W-2 form at the end of the year and is taxed as wages. You may avoid this tax liability by waiving Basic Life Insurance coverage above $50,000. However, the protection from the additional amount of life insurance may outweigh the tax consequences, so you should consult a tax advisor before making a decision.

You may waive Basic Life Insurance coverage in excess of $50,000 coverage when making your enrollment selections on-line by choosing the Basic Life Insurance $50,000 option.

Accelerated Death Benefits

If, while insured by the plan, you or a covered dependent becomes terminally ill with a life expectancy under 12 months, you may request to have a portion of the life benefit paid as an accelerated benefit. The one time payment will be based on 100% of your life insurance and 90% of your dependent's life insurance and will not be greater than $250,000. The amount of life insurance remaining will be reduced by the amount of accelerated benefit paid. You should discuss this with a representative of the Benefits Office if you or your covered dependent have been diagnosed as having significantly impaired life expectation.

Age 65 Benefit Reductions

If you are still an active employee and covered by the plan at age 65, your Basic Life, Additional Life, and AD&D coverage will be reduced according to the following schedule:

Age	Percentage of Your Pre-Age-65 Coverage Amount
65-69	65%
70-74	45%
75-79	30%
80 and over	20%

If You Become Disabled

If you become disabled and stop active work by being placed on a personal medical leave of absence, the following is how your life insurance coverage proceeds.

Basic Life Insurance coverage will continue with no premium due from you for up to six months from the start of your disability. If you continue to be disabled beyond six months, you may elect to convert your Basic Life coverage to an individual policy as outlined in the “Conversion Option” section of the guide.

Additional Life Insurance coverage can be continued for the first six months (180 days) of your disability by paying the premium directly to the Hospital. If you continue to be disabled beyond six months, coverage (up to $750,000) has a waiver of premium provision for those who become disabled before the age of 60. The waiver of premium allows your Additional Life Coverage to continue without further premium payments for the duration of your disability or until you reach age 65.

If you are age 60 or above when you become disabled, the waiver of premium does not apply. You have 30 days from the start of your disability or from when your last Additional Life Insurance payment was made to the Hospital to elect to convert your Additional Life Insurance coverage to an individual policy as outlined in the “Conversion Option” section of the guide.

Dependent Life Insurance coverage (spouse and children) can be continued for the first six months of a disability by paying premium(s) directly to the Hospital. If you continue to be disabled beyond six months, you may elect to convert your Dependent Life Insurance to individual coverage as outlined in the “Conversion Option” section of this booklet. You have 30 days from your last direct payment to elect conversion.

Accidental Death & Dismemberment coverage can be continued for the first six months of a disability by paying premium directly to the Hospital. If you continue to be disabled beyond six months, your AD&D coverage terminates. There is no AD&D conversion option.

AD&D coverage exclusions

- Intentionally self-inflicted injuries, or any attempt to inflict such injuries.
- Suicide or attempted suicide, while sane or insane.
- War, or any act of war, declared or undeclared, and resistance to armed aggression.
- An accident that occurs while you are serving on full-time active duty for more than 30 days in any armed forces. This exclusion does not include Reserve or National Guard active duty for training.
- Sickness, whether the Loss results directly or indirectly from the sickness.
- Medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment
- Any infection except a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance.
- Travel or flight in any vehicle used for aerial navigation. This includes getting in, out, on or off any such vehicle. This applies only if you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers, performing as a pilot or a crew member of any aircraft or riding as a passenger in an aircraft owned, leased or operated by your Employer.
- Commission of or attempt to commit a felony.
- Being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a Doctor.
- Participation in these hazardous sports: scuba diving, bungee jumping, skydiving, parachuting, hang gliding or ballooning.

Life Insurance Conversion Option

When coverage ends, you have 31 days to opt to convert your Basic Life, Additional Life and/or Dependent Life to an individual policy without submitting evidence of insurability. You cannot convert AD&D coverage.

You pay the entire cost of any coverage that you convert to an individual policy. To request coverage conversion, you must submit a conversion form to the life insurance carrier. You should receive this form from the COBRA administrator. Additional forms are available in the Benefits Office:

555 West 57th St. 19th Floor
New York, NY 10019
(212) 523-5193

The Short Term Disability Plan

For Associates Who Work in New York

The Short Term Disability Plan provides certain income if you are disabled and are unable to work due to non-occupational illness or injury.

When Coverage Begins

If you were covered by a previous employer or collecting unemployment insurance for three months before you were employed by the Hospital Center, you are eligible for Short Term Disability (STD) coverage under the New York state-insured Disability Benefit Law (DBL) as of your date of hire. If you were *not* employed or collecting unemployment insurance for the previous three months, your coverage begins after four consecutive weeks of employment with the Hospital Center.

If you are a part-time non-temporary employee, please refer to "Eligibility for Benefits" on page 6.

When Coverage Ends

Short Term Disability (STD) coverage ends four weeks after your date of termination. That is, you may apply for Short Term Disability if you become sick or disabled within (4) weeks after the termination of employment.

Cost of Coverage

The bi-weekly cost of your coverage is $1.20, which is deducted automatically from your pay.

Short Term Disability (STD) Benefits

STD benefits for medically substantiated leaves include two components – full pay, to the extent you have earned sick time; or statutory DBL payments, if you have no earned sick time or your sick time exhausts while on leave. The maximum short term disability period is 26 weeks (180 days) which includes any time that you are absent whether you are paid earned sick time or DBL payments.

If you are unable to work because of a disabling non-occupational illness, injury, or pregnancy, you may be eligible for STD benefits. The disability period begins on the eighth consecutive day absent and may continue for up to the 26-week maximum during 52 consecutive calendar weeks. The maximum DBL benefit is $170 per week.

If benefits are payable for a *partial* workweek, payments are prorated based on a five day workweek.

Definition of Disability

For plan purposes, disability means that you are unable to perform the regular duties of your job or any other job which your employer may offer you at your regular wages (and which your injury or sickness does not prevent you from performing). You must be under the care of a legally qualified physician during the period benefits are payable.

To Receive Benefits

You must follow the procedures outlined in the Leave of Absence (LOA) policy. The policy and associated forms are available on the Intranet under *Human Resources, Leaves of Absence*. You may also contact the Benefits Office at (212) 523-5193 to obtain the policy and forms. Benefits are payable only for leaves that are medically substantiated by the insurance carrier. Leaves that are Family Medical Leave Act (FMLA) leaves only must be medically "certified" by the insurance carrier in accordance with the FMLA regulations.

Successive Disabilities

If you become disabled again as a result of the same or a related cause within three months, the seven-day waiting period will be waived and the first period of disability will count towards your maximum entitlement of 26 weeks of STD benefits. This means that STD benefits will only resume if you previously received less than 26 weeks of benefit payment.

If the subsequent disability results from causes unrelated to the first disability, benefits are subject to the seven-day waiting period. You should note, however, that the first period of disability would still count towards your maximum entitlement of 26 weeks of STD during a consecutive 52-week period.

Exclusions

This plan will not cover any disability due to:

- War, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries, while sane or insane
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor
- Cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person
- A gender change, including but not limited to any operation, drug therapy or any other procedure related to a gender change

No benefit will be payable during any period of incarceration.

Conversion of the STD Plan

Short Term Disability coverage ends four weeks after your date of termination. You cannot convert STD coverage.

For Associates Who Work in New Jersey

The Short Term Disability Plan provides certain income if you are disabled and are unable to work due to non-occupational illness or injury.

When Coverage Begins

You are eligible for Short Term Disability (STD) coverage under the New Jersey Temporary Disability Benefit (TDB) as of your date of hire.

When Coverage Ends

Short Term Disability coverage ends 14 days after your date of termination. That is, you may apply for Short Term Disability if you become sick or disabled within 14 days after the termination of employment (unless you are terminated for gross misconduct).

Cost of Coverage

For 2009, the cost of your coverage is 0.5% of the first $28,900 annual earnings. The 2009 maximum contribution is $144.50. The contribution amount is subject to change annually. Contributions are deducted automatically from your pay.

Short Term Disability (STD) Benefits

If you are unable to work because of a disabling non-occupational illness, injury or pregnancy, you may be eligible for STD benefits. The disability period begins on the eighth consecutive day absent and may continue for up to a 26-week maximum during 52 consecutive calendar weeks. The 2009 maximum TDB benefit is $546 per week.

Definition of Disability

For plan purposes, disability means that you are unable to perform the regular duties of your job. You must be under the care of a legally qualified physician, dentist, optometrist, practicing psychologist, podiatrist, advance practice nurse or chiropractor. If not a physician, the practitioner may only certify a disability within his/her specialty.

To Receive Benefits

You must follow the procedures outlined in the Leave of Absence (LOA) policy. The policy and associated forms are available on the Intranet under *Human Resources, Leaves of Absence*. You may also contact the Benefits Office at (212) 523-5193 to obtain the policy and forms. Benefits are payable only for leaves that are medically substantiated by the insurance carrier. Leaves that are Family Medical Leave Act (FMLA) leaves only must be medically "certified" by the insurance carrier in accordance with the FMLA regulations.

Successive Disabilities

Different periods of disability due to the same or related conditions will be deemed one period unless separated by 14 days, provided that you have earned wages from the employer during such 14-day period.

Exclusions

This plan will not cover any period of disability due to:

- Willfully and intentionally self-inflicted injury
- Injury sustained in the perpetration of a crime of the first, second or third degree

Conversion of the STD Plan

Short Term Disability coverage ends 14 days after your date of termination. You cannot convert STD coverage.

The Long Term Disability Plan

Basic Long Term Disability

If you remain continuously disabled beyond the 180-day elimination (waiting) period, you may be eligible to receive Long Term Disability (LTD) benefits. If you return to work during the LTD elimination period, your disability will be treated as continuous if your disability stops for 45 days or less during the 180-day period. The days that you are not disabled will not count toward your elimination period. LTD disability benefits include occupational and non-occupational illnesses or injuries. The employer-provided LTD coverage is 50% of your annual base salary, with a maximum monthly benefit of $2,000. This is employer provided coverage and you do not contribute toward the cost of this benefit.

The Basic LTD plan does not apply to associates eligible for Executive Long Term Disability coverage.

Tax Options

Your employer pays 100% of the cost of your Basic LTD coverage. Under present regulations, if your employer pays your long-term disability premiums, benefits you receive are fully taxable. To assure that you receive the maximum benefit, your employer offers the option to include the premium paid on your behalf in your taxable income (referred to as imputed income).

You must decide at the time you make your benefit selections, whether or not to pay taxes on the premium paid on your behalf for LTD benefits that may be received.

You should speak with a tax advisor before making your selection.

Basic LTD Non-taxable Benefit Option

You may elect to pay tax on the income used to pay premiums on your behalf. The amount imputed as income is determined based on your salary and your age and is added to your taxable income on a biweekly or weekly basis. The portion of the disability benefit you paid taxes on will not be included as taxable income if you receive benefits under the plan. Therefore, LTD benefits received could be equal to 50% of your pre-disability earnings, up to the maximum benefit (assuming the entire benefit is received tax-free). You must indicate on-line if you wish to have this non-taxable option.

Basic LTD Taxable Benefit Option

You may elect not to pay tax on the income used to pay premiums on your behalf. When you elect this option, LTD benefits received will be fully taxable.

Additional Long Term Disability

You may also purchase additional LTD coverage. For BI/SLR the additional LTD combined with your basic LTD coverage would equal up to 60% of your base salary with a maximum monthly benefit of $10,000. For LICH the additional LTD combined with your basic LTD coverage would equal up to 66⅔% of your base salary with a maximum monthly benefit of $8,000.

The Additional LTD plan does not apply to associates eligible for Executive Long Term Disability coverage.

Additional LTD Tax Option:

If you choose the Additional Long Term Disability plan, payroll deductions will be taken on an after-tax basis. The portion of benefits *paid* under the Additional Long Term Disability plan will not be taxed.

Pre-Existing Condition Provision

You have a pre-existing condition when you apply for coverage when you first become eligible if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage.
- Your disability begins in the first 12 months after your effective date of coverage unless you have been treatment free for 3 consecutive months after your effective date of coverage.

The pre-existing condition provision applies to Basic and Additional coverage obtained during initial eligibility period, the open enrollment period and/or if you alter coverage due to a qualifying change in status as defined on page 9.

Definition of Disability for Long Term Disability

- For **managers, physicians and executives (BI/SLR only)**, you are considered disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and you have a 20% or more loss in your indexed monthly earnings due to the same sickness of injury.

  You may be required to be examined by a physician, other medical practitioner and/or vocational expert of the carrier's choice. The carrier will pay for this examination. You can be required to have the examination as often as it is reasonable to do so. You may also be required to by interviewed by an authorized representative of the carrier.

- For **all other employees covered under the plan**, you are considered disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury. After a period of 24 months, you are considered disabled if due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

  You may be required to be examined by a physician, other medical practitioner and/or vocational expert of the carrier's choice. The carrier will pay for this examination. You can be required to have the examination as often as it is reasonable to do so. You may also be required to by interviewed by an authorized representative of the carrier.

Maximum Duration of LTD Payment

Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Mental Illness Disability Limitation

Disabilities due to mental illness have a limited pay period up to 24 months.

The carrier will continue to send you payments beyond the 24 month period if you meet one or both of these conditions:

1. If you are confined to a hospital or institution at the end of the 24 month period, the carrier will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, the carrier will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, the carrier will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to item 1, if, after the 24 month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, the carrier will send payments during the length of the reconfinement.

The carrier will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever comes first.

The carrier will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatments

Base Annual Salary

Means the yearly salary or wage you receive for work done. It does not include bonuses, overtime pay, shift differentials, experience differentials or education differentials.

Survivor Benefit

The LTD carrier will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death, your disability had continued for 180 or more consecutive days and you were receiving or were entitled to receive payments under the plan.

Deductible Sources of Income

The following are examples of deductible sources of income from your gross disability payments:

- Workers' compensation
- Social Security
- Automobile liability insurance policy
- Other group insurance plan
- Voluntary elect to receive as retirement payments under your Employer's retirement plan
- Receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in the Employer's retirement plan.

Conversion of LTD Benefits

Basic LTD and Additional LTD coverage may be converted to individual coverage, subject to evidence of insurability (underwriting) requirements, if requested within 30 days from the end of coverage. To request coverage conversion, you must submit a conversion form. You pay the entire cost of any coverage that you convert to an individual policy. To request coverage conversion, you must submit a conversion form to the LTD carrier. You should receive this form from the COBRA administrator. Additional forms are available in the Benefits Office:

555 West 57th St. 19th Floor
New York, NY 10019
(212) 523-5193

For LICH employees, this conversion option is not available.

Business Travel Accident Insurance

The Business Travel Accident Insurance Plan is designed to pay benefits in the event of your accidental death and injury while traveling on Hospital Center business.

- The amount of Principal Sum for Administrators and Physicians is $500,000.
- The amount of Principal Sum for all Nurses and other employees is $50,000.

The Principal Sum applicable to any insured person shall be the percentage shown in the following schedule: Premium for insured persons age 70 and older will be based on 100% of the Principal Sum prior to reductions.

Age at Date of Loss	Principal Sum
Age 69 or younger	100%
70-74	65%
75-79	45%
80-84	30%
85 or older	15%

Benefits specifically provided for insured persons age 70 and older which are in conflict with the above amendments remain unchanged by this rider.

In all other respects the policy remains the same.

When a covered injury results in any of the following losses to an insured person within 180 days after the date of the accident, the following benefits apply:

Table of Losses

Description of Loss	Indemnity
For Loss of:	
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Either Hand or Foot	½ the Principal Sum
Sight of One Eye	½ the Principal Sum

Exclusions

The policy does not cover any loss, fatal or non-fatal, caused by or resulting from:

- suicide or any attempt thereat by the Insured Person while sane OR self-destruction or any attempt thereat by the Insured Person while insane (in Missouri, while sane);
- disease of any kind;
- bacterial infections except pyogenic infection which shall occur through an accidental cut or wound;
- hernia of any kind;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in Part B of Section II, Definition of Injury and Scope of Coverage;
- declared or undeclared war or any act thereof;
- service in the military, naval, or air service of any country.
- flying in any aircraft being used for or in connection with acrobatic or stunt flying, racing or endurance tests;
- flying in any rocket-propelled aircraft;
- flying in any aircraft being used for or in connection with crop dusting or seeding or spraying, fire fighting, exploration, pipe or power line inspection, any form of hunting, bird or fowl herding, aerial photography, banner towing or any test or experimental purpose, unless previously consented to in writing by the Company;
- flying in any aircraft which is engaged in any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted, unless previously consented to in writing by the Company;
- flying in any aircraft owned or operated by the Policy Holder, unless previously consented to in writing by the Company.

Enrollment Process

New Enrollments (new hires and newly eligibles)

You have 30 days from your date of hire or the date you become eligible for benefits coverage (i.e., per diem to full time) to choose your benefits in the *BenElect*™ on-line enrollment system. This includes opting out of medical coverage (waive) if you are covered under another group medical plan. If you do not make your selections within the 30-day period, the Hospital will assign benefits (default) coverage as follows:

- Empire EPO Medical Plan – employee only coverage
- Basic Life Insurance Plan – 1x annual base salary
- Basic Short-term Disability (STD) Plan
- Basic Long-term Disability (LTD) Plan – taxable

Please note that you will have no dental coverage unless you proactively enroll via *BenElect*. You will also not have medical coverage for your eligible dependents unless you proactively enroll via *BenElect*.

You **will not** have an opportunity to change your default coverage until the next annual open enrollment period or untless you have a qualifying family status change.

Dependent Coverage

If you are covering your spouse and/or your child(ren) for the first time, you are required to send supporting documents (i.e., proof of marriage, child's birth certificate, proof of domestic partnership) to the Benefits Office–or fax them to (212) 523-5610–within 10 days of your election. Please refer to "Who Is Eligible for Coverage" on page 7 for further details regarding your eligible dependents.

Coverage for your eligible dependents may be interrupted if you fail to submit the required documents within 10 days of enrollment.

Annual Open Enrollment

Once each year you have the opportunity to review your existing benefits and make changes in coverage for the following year**. This is the only opportunity you will have to make changes to your plan unless you have a qualified family status change.**

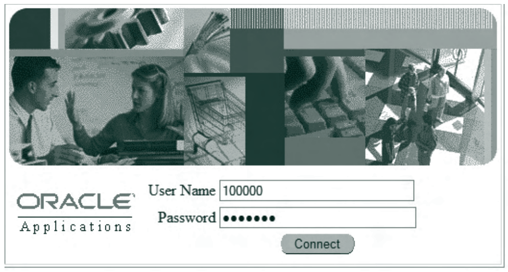
During open enrollment you should review your existing benefits. If you wish to make any changes or participate in the Flexible Spending Accounts for the upcoming year, you must do so during this enrollment period using the *BenElect* on-line enrollment system.

Making Your Benefit Elections On-line

If you wish to initially enroll for benefits, view your existing coverage, or make changes to your benefits (during the annual open enrollment), you must use the *BenElect* on-line enrollment system. Please follow these steps:

To log into *BenElect*:

- Access the Continuum website (intranet.chpnet.org from a computer within the Continuum network, or www.wehealny.org from an offsite computer).
- Click once on the "*BenElect* Login" link.
- Scroll down and click once on the "Enter Here" link.



- Your "User Name" is your employee identification number (as it appears on your paycheck). If this is your first time using Oracle, your default password is the first four digits of your social security number plus the month (MM) and day (DD) of your birth date. You will be prompted to change your default password. Your new password must be at least 8 characters and include both letters and numbers. If you have previously changed your default password, enter your established password.
- Click on "CHP Self Service Benefits".

If you are unable to log in, please contact the IT Helpdesk at (212) 523-6486.

Voluntary Benefits Program

The Voluntary Benefits Program is offered in addition to your other benefits and is intended to give you an opportunity to better address your individual insurance needs. Premiums are paid through convenience of payroll deductions.

Eligibility

You are eligible to apply for the following insurance plans if you are a union or non-union employee who works at least 20 hours per week, and have been actively at work for at least three months.

The Farmington Company services the following voluntary benefit plans:

Life Insurance*

Own and control your life insurance.

- Family Coverage – employee, spouse and children.
- Cash values accumulate tax-deferred.

Disability Insurance

How would you pay your bills if you were unable to work?

- Choose a level of coverage that best meets your individual financial needs.
- Benefits are payable up to 2 years.
- Benefit payments are tax-free.

Cancer Insurance

Enhance your medical coverage and get additional much-needed dollars.

- Benefits are paid directly to you and in addition to major medical.
- First occurrence benefit – pays lump sum upon diagnosis of cancer.
- Covers in-patient or out-patient hospital visits.
- Includes annual cancer screening wellness benefit.

For more information, contact Farmington at (800) 621-0067. To view program details on-line go to www.farmingtonco.com, Plan Information, and enter the User ID: cnhp01 and Password: cnhp2005.

* *For LICH employees, life insurance policies are offered through Winston Financial Services.*

For LICH employees interested in Voluntary Life Insurance, contact Winston at (800) 347-6071 or use e-mail at customerservice@winstonfinancial.com.

Other Offerings Under the Voluntary Benefits Program

In addition to the benefits outlined above, the following plans and programs are offered:

- **Voluntary participation in Fidelity Investments 403(b) Retirement Savings Plan** – To enroll in Fidelity Investments, call Fidelity Retirement Services at (800) 343-0860 or go on-line at www.fidelity.com/atwork.
- ***Etrac* Transit Program** – The QTE Plan allows you to pay for workplace commuting via mass transit and/or workplace parking with tax-free dollars. Continuum employees may enroll the first seven days of each month. To enroll, call (866) myetrac (693-8722) or go on-line at www.ibenefitresource.com. Your login is your social security number and the PIN is the last 4 digits of your social security number.
- **Municipal Credit Union** – Offers a full range of financial services. For more information, go on-line at www.nymcu.org or visit a Municipal Credit Union branch.
- **People's Alliance Federal Credit Union** (for LICH Employees only) – For financial services, visit your local People's Alliance Federal Credit Union.
- **The National Group Legal Benefit Plan ("Gold Cross Legal")** – This plan provides services such as legal advice via telephone; review of legal documents, contracts, leases, etc.; preparing wills and will updates; health care proxy; living will; and an emergency 24 hour hotline for individuals confronted with a situation that requires immediate legal advice. For more information, call (800) 292-8063. You may enroll only during an open enrollment period that will be communicated in advance. You may disenroll at any time after 12 months of continuous group legal plan participation by contacting the Benefits Office at (212) 523-5193.
- **John Hancock Long Term Care Insurance** – This insurance is designed to help you plan for the unexpected and help protect you against the high cost of care and services associated with a severe illness, injury, or supervision due to a cognitive impairment. If you are unable to care for yourself, the John Hancock Long Term Care policy will cover the cost of long term care services provided to you in a nursing home, an adult day care center, an assisted living facility, or in your own home. For more information and to enroll, call Michael Klein at his office, (516) 794-9696 x57, or his cell phone, (516) 782-6541. You may also e-mail him at MKlein@JHnetwork.com
- **Equinox Fitness Clubs** – You may join at discounted rates through convenient payroll deductions. The enrollment deadline is the 20th of every month. For more information and to enroll, email Adin Alai at aalai@equinoxfitness.com.

Your Right to Continue Health Coverage Under COBRA

Under a federal law called the Consolidated Omnibus Reconciliation Act of 1985, as amended, (COBRA), you and your enrolled dependents, and any newborn or newly adopted child may be able to temporarily continue group health care coverage for a period of time after your coverage as a qualified employee or dependent ends (called "continuation coverage"), if any of the following events occur:

- The termination of your employment (voluntarily or involuntarily, for reasons excluding gross misconduct)
- Your hours are reduced so that you are no longer eligible for the group plan;
- Your death;
- Your divorce or legal separation;
- Your entitlement to Medicare;
- Your child no longer qualifies as a dependent;

In addition, there may be a right to continuation coverage for certain eligible employees and their dependents if a Title II bankruptcy proceeding is commenced with regard to your employer. If this occurs, you should contact the Plan Administrator concerning your rights.

Additionally, if during your participation in a continuation coverage you acquire a new spouse and/or a dependent, you are entitled, to the extent the group health plan provides such enrollment rights to similarly situated active employees or to the extent permitted under applicable law (including, but not limited to, Treas. Reg. 54.4980B-5, Q&A-5 and Treas. Reg. 54.4980B-3, Q&A-1), to enroll such individual(s) under such continuation coverage for the remainder of the continuation coverage period to which you are entitled under COBRA.

How Long You May Continue Coverage

You may continue coverage for up to 18 months in the event of:

- the termination of your employment (voluntarily or involuntarily, except if you are fired for gross misconduct); or
- a reduction in your hours so that you are no longer eligible for the group plan.

If you or your eligible dependents were disabled according to the Social Security Act at the time your employment ended or your hours are reduced, you or your eligible dependents may continue coverage for an additional 11 months (up to 29 months) if your disability continues during that period.

To have coverage extended, the requirements highlighted below must be met

- the Plan Administrator must be notified of the disability within 60 calendar days of being determined disabled by Social Security,
- the date of Social Security rendering you totally disabled must fall before your COBRA effective date or within the first 60 days of your COBRA continuation coverage and
- The determination by Social Security must occur within the first 18 months of COBRA coverage.

You will also have to notify the Plan Administrator within 30 calendar days of the day that Social Security determines that you are no longer disabled. Once you notify the Plan Administrator, COBRA coverage will end, effective the month beginning 30 calendar days after Social Security determines you are no longer disabled.

Your spouse and any enrolled dependents may choose to continue coverage and pay full premiums for up to 36 months for your enrolled dependent(s) in the event of:

- your death;
- your divorce;
- legal separation;
- if you become entitled to Medicare after electing COBRA ; or
- if your child no longer qualifies as a dependent under the terms of the plan.

If you have or adopt a child while covered under COBRA, that child will be covered under COBRA. The newborn or adopted child will be covered as of the birth or adoption date and will not be subject to the pre-existing condition limitations as long as you notify the Plan Administrator within 30 calendar days of the birth or adoption. This provision also applies to children who are placed with you for adoption, before the final adoption has officially occurred.

If a qualifying event occurs and an 18 month continuation coverage is triggered, your spouse, enrolled dependent or newborn or adopted child will be eligible for an additional 18 months of coverage if a second COBRA qualifying event occurs. A second qualifying event includes:

- your death;
- your divorce;
- legal separation;
- if you or your spouse become eligible for Medicare; or
- if your child no longer qualifies as a dependent.

If there is a proceeding under the United States Bankruptcy Code involving the employer from whom you have retired, your continuation coverage will end when you die, and continuation coverage for you dependents will end 36 months after the date of your death.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The employer reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible. Once your continuation coverage terminates for any reason, it cannot be reinstated.

How to Arrange for Continuation of Benefits

You must notify the Plan Administrator – You or your enrolled dependent(s) must notify the Plan Administrator: St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital (555 West 57th St. 19th Floor, New York, NY 10019) in writing within 60 calendar days following a divorce, legal separation, medicare entitlement, or when a child no longer qualifies for coverage as a dependent under the terms of the plan.

The Plan Administrator (via the COBRA Plan Administrator) will notify you, your spouse, or dependent children of the right to elect continuation coverage in the event of the termination of your employment, your reduction in hours so that you are no longer eligible for the group plan, or your death.

The COBRA Plan Administrator will notify you of your COBRA rights - You or your enrolled dependent(s) have 60 calendar days from the date coverage ends (or, if later, from the date you are notified of your COBRA rights) to choose to continue coverage. You will then be given information on your continued coverage rights. In the event that you are ineligible for COBRA coverage, or if you are not entitled to an extension of COBRA coverage due to a second qualifying event, the COBRA Plan Administrator must provide you with a notice of ineligibility.

Payment of COBRA premiums - You must pay the first COBRA premium within 45 calendar days after you elect COBRA coverage. The COBRA premium includes the full cost of the coverage, on an after tax basis, plus a 2% administrative charge. However, during the additional 11 months of continuation coverage (for disability), you may be required to pay up to 150% of the applicable premium. If you elect to continue coverage, coverage will be identical to similarly situation active employees and their enrolled dependent(s).

Payments must be submitted to the COBRA Plan Administrator:

Ceridian COBRA National Service Center
3201 34th St South
St. Petersburg, FL 33711

Coverage is effective as of the date of the qualifying event if you have elected COBRA continuation coverage. The first premium payment is due within 45 days after the election for COBRA continuation coverage is made. Premium payments are due thereafter on a monthly basis, no later than 30 calendar days after the monthly due date and should be mailed directly to the COBRA Plan Administrator.

When Continuation of Coverage May End

The Plan Administrator has the right to end continued coverage if:

- The Plan Administrator stops providing health care coverage for all employees;
- you or your enrolled dependents do not pay premiums within the grace period;
- after electing COBRA, you or your enrolled dependent(s) become covered under Medicare;
- after electing COBRA, you become covered under another group plan which has no pre-existing condition clause with respect to any condition your or your enrolled dependent(s) may have; or
- your COBRA coverage was extended for up to 29 months due to a disability and you received a final Social Security determination that you are no longer disabled.

Converting to an Individual Policy

When your COBRA continuation coverage ends, you and your enrolled dependent(s) may obtain an individual health care policy from the insurance carrier. You or your enrolled dependent(s) are eligible for this conversion privilege if you have had medical coverage and are not eligible for Medicare. You may convert without showing proof of good health.

To convert to an individual coverage, you have 30 days to apply to the insurance carrier and pay the required premium.

Family Medical Leave

Under the Family and Medical Leave Act (FMLA), you may be eligible to take up to 12 weeks of time off for the care of yourself or a qualified family member due to a serious health condition. Under the St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital Medical Leave Policy (Medical Leave), you may be eligible to take up to 6 months of time off for the care of yourself due to a serious health condition. If you are approved for FMLA or Medical Leave, your health care coverage will continue as if you were an active employee, provided you pay the biweekly contributions. At the conclusion of your FMLA or Medical Leave, you may be eligible for benefits under COBRA if:

- You or your enrolled dependents are covered on the day before the first day of FMLA or Medical Leave or become covered during the FMLA or Medical Leave under a group health plan.
- You do not return to employment at the end of the FMLA or Medical Leave; and
- Your or your enrolled dependent(s) would, in the absence of COBRA, lose coverage under the group health plan before the end of what would be the maximum coverage period. In other words, you would no longer be covered under the same terms and conditions as those in effect for similarly situated active employee and their enrolled dependent(s).

Your COBRA continuation period will begin at the end of your FMLA or Medical Leave. For example, if you take FMLA leave and later decide not to return to work your COBRA continuation of coverage would begin on the day after the end of FMLA leave. If you notify St. Luke's-Roosevelt Hospital Center, Beth Israel Medical Center, or Long Island College Hospital that you do not plan to return to work, your COBRA continuation period will begin on the day after your termination.

However, please note that you would not be eligible for COBRA if St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital were to eliminate group health plan coverage for its active employees during your FMLA or Medical Leave.

Continuation of Coverage for Domestic Partners

Although a Domestic Partner (and his or her dependent children) does not have rights to COBRA coverage under existing federal law, Continuum has decided to offer continued coverage in certain cases. ***This is not COBRA coverage and, as such, the Company retains the right to modify or terminate this continuation of coverage benefit at any time.***

- The "COBRA" rate applicable to the underlying plan(s) will be charged for the coverage. It is intended that charging the applicable "COBRA" rate will eliminate income tax to an employee or former employee for the value of the extension of coverage.
- A Domestic Partner (and his or her dependent children) may continue to be covered (or added to coverage) under the plan(s) after an employee's termination. The continuation of coverage would last up to 18 months.
- Unlike COBRA, which would provide no coverage, Continuum will allow a covered Domestic Partner (and his or her dependent children) to continue coverage for up to 36 months following the death of the employee, at the COBRA rate applicable to such plan(s). Domestic Partners and eligible dependent children who are not covered under the plan(s) at the time of the employee's death would not be eligible for this continuation. If a former employee died during the COBRA coverage period, this 36-month period of coverage would commence on the date of the former employee's first qualifying event (e.g. termination of employment).

- Unlike COBRA, which would provide no coverage, Continuum will allow a covered Domestic Partner (and his or her dependent children) to continue coverage, at the COBRA rate applicable to such plan(s), for up to 36 months from the date of the employee's first qualifying event (if any), if coverage would otherwise be lost following Medicare entitlement of the employee. Thus, Domestic Partners and eligible dependent children who are not covered by the plan(s) at the time of the employee's Medicare entitlement would not be eligible for this continuation.
- Unlike COBRA, which would provide no coverage, Continuum will allow a covered dependent child of a Domestic Partner to continue coverage for up to 36 months, at the COBRA rate application to such plan(s), when he or she would otherwise lose coverage as a result of reaching the age at which he or she is no longer eligible to be covered as a dependent child under the terms of the underlying plan(s).
- In no event shall the Domestic Partner (and his or her eligible dependent children) be permitted to continue this coverage beyond the date of the termination of the relationship (except where termination of the Domestic Partner relationship is caused by the death of the employee or former employee).
- In no event shall the Domestic Partner (and his or her eligible dependent children) be permitted to continue this coverage beyond the date that Domestic Partner coverage is terminated with respect to Domestic Partners of similarly situated active employees.
- In no event shall the Domestic Partner be permitted to continue this coverage beyond the date that the Domestic Partner becomes eligible for coverage under Medicare (unless eligibility for Medicare is solely as the result of end-stage renal disease).
- You are required to notify the Plan Administrator or designated representative upon the occurrence of any event that would result in a lapse of coverage.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996 and directed the U.S. Department of Health and Human Services to issue various rules known as the HIPAA regulations. These rules addressed a few topics including:

1. Health care portability features that placed limits on the preexisting condition exclusions from health care coverage. This means that when you, your spouse or dependents lose coverage under St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital's group health plan, the covered individuals will be given a certificate, which provides evidence of prior health coverage. You may need to furnish this certificate to another employer if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll.
2. Nondiscrimination rules for health plans (affecting premiums, contributions, wellness programs, "at-work" coverage requirements, etc.).
3. The HIPAA privacy rule contains provisions requiring group health plans to protect the confidentiality of your private health information. The privacy rule also provides for certain individual rights relating to uses and disclosures of your health information by health plans.

   Beginning on April 14, 2003, Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, and Long Island College Hospital as the sponsors of the St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital group health plan, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law.
   By law, the St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital group health plan will require all of its business associates to observe HIPAA's privacy rules. In particular, the St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital group health plan will not, without proper authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, and Long Island College Hospital.

Under the HIPAA privacy rule, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital group health plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

The St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital group health plan will maintain, on or after April 14, 2003, a privacy notice, which provides a complete description of your rights under the HIPAA privacy rules. For a copy of the notice, please contact the Benefits Office. If you have questions about the privacy of your health information, please contact the Benefits Office or the St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital group health plan's designated privacy official. If you wish to file a complaint under the HIPAA privacy rule, please contact St. Luke's-Roosevelt Hospital Center/Beth Israel Medical Center/Long Island College Hospital's group health plan's complaint manager.

ERISA

As a participant in any of the benefit plans described in this booklet or a beneficiary receiving benefits, you are entitled to certain right and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Except for the Dependent Care Spending Account, all plans in this booklet are regulated by ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants 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 ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

General Plan Information

- The Continuum Benefits Program is the name of the Plan.
- Your Employer has assigned number 520 to your Plan.
- The provisions of the Plan described in this Summary Plan Description became effective on January 1, 2006.
- Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31. The date of the end of the year for maintaining the fiscal year plan records is December 31.
- This is a welfare plan. Therefore, your benefits are not insured by the Pension Benefit Guaranty Corporation (PBGC), an agency of the federal government. The PBGC generally requires or provides insurance for certain pension plans only.

Employer Information

- Your Employer's name and address are:

  Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center, Long Island College Hospital
  555 West 57th Street, 19th floor
  New York, NY 10019

- Your Employer's federal employer tax identification number (EIN):

  - Beth Israel Medical Center 13-5564934
  - St. Luke's-Roosevelt Hospital Center 13-2997301
  - Long Island College Hospital 11-1018985

Plan Administrator Information

- The name, address and business telephone number of the Plan Administrator of your Plan are:

  Continuum Health Partners
  555 West 57th Street, 19th floor
  New York, NY 10019
  Attention: Human Resources Administrator
  Telephone: 212-523-5193

- The Administrator appoints the Human Resources Administrator to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Benefits Committee acts on behalf of the Administrator with respect to appeals. The Human Resources Manager will answer any questions that you may have about our Plan. You may contact the Human Resources Manager at the above address for any further information about the Plan.
- The Health FSA Component is a group health plan. It is a contract administration plan. A third-party administrator processes claims for the Plan, but the Employer pays all claims out of its general assets.

Service of Legal Process

- The name and address of the Plan's agent for service of legal process is:

  Continuum Health Partners
  555 West 57th Street, 19th floor
  New York, NY 10019
  Attention: Legal Department

  In addition, legal process may also be made upon the Plan Administrator

Funding Medium and Type of Plan Administration

Your Empire Medical, Medco Prescription Drug, Hearing for BI/SLR, Guardian Dental, Vision and Flexible Spending Account Plans are "self-insured" benefits. Continuum has hired an administrator for each benefit to process claims under the Plan. The administrators for these benefits do not serve as insurers, but as claims processors. Claims for benefits are sent to the applicable administrator. The applicable administrator processes the claims, the requests and receives funds from Continuum to pay the claims, and makes payments on the claims to other providers. Continuum is ultimately responsible for providing Plan benefits, and not the applicable administrator. (Note that Continuum and the applicable administrator share responsibility for administering the Plan)

Benefits are paid directly out of the general assets of Continuum. There is no special fund or trust from which benefits are paid.

The HIP Medical, HIP prescription drug, Empire Dental, Life Insurance Plan, and the LTD Plan are "fully-insured" by their respective insurance companies. Benefits are provided under a group insurance contract entered into between the respective insurance company and Continuum. Claims for benefits are sent to the insurance company. The insurance company is responsible for paying claims for your fully insured plans, not Continuum. (However, the insurance company and Continuum share responsibility for administering the plans.)

Insurance premiums for Employees and their families are paid in part by Continuum out its general assets, and in part by employees' payroll deductions. For more information, refer to the section titled "Paying for Coverage."

Subrogation and Reimbursement

When another party is liable, or alleged to be liable for, any benefit that you receive under the terms outlined in this SPD, either Continuum or the insurance company listed in this document may be subrogated to your rights against the other party. This means that Continuum or the insurance company has the right, independently of you, to proceed against the other party and pursue a recovery of benefits. You are obligated to cooperate with Continuum and the applicable insurance company in the recovery of the benefits. Please refer to the applicable Plan document for details on subrogation and reimbursement. This SPD does not contain a detailed description of subrogation rights.

Termination or Amendment of Plan

The Employer expects to maintain the Plan indefinitely as a program of employee benefits. However, the Employer has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan Participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

Administrative Information

For More Information

If you have questions about:	Contact:	
Enrollment	Benefits Office – Human Resources 555 West 57th Street, 19th floor New York, NY 10019 *Phone:* (212) 523-5193	
Empire BlueCross BlueShield PPO & Empire EPO	Empire BlueCross BlueShield *Phone:* (800) 952-7695	*Website:* www.empireblue.com
Medco Prescription Drug Coverage (Empire BC/BS PPO and Empire EPO)	Medco Health Solutions *Phone:* (800) 711-0917	*Website:* www.medco.com
HIP POS	HIP *Phone:* (800) 447-8255	*Website:* www.hipusa.com
Guardian Dental	Guardian Dental *Phone:* (800) 541-7846	*Website:* www.guardianlife.com
Empire Managed Dental	Empire BlueCross BlueShield *Phone:* (800) 722-8879	*Website:* www.empireblue.com
UnitedHealthcare Vision	UnitedHealthcare *Phone:* (800) 638-3120	*Website:* www.myuhcvision.com
Hearing Coverage	Benefits Office *Phone:* (212) 523-5193	
Prudential Life Insurance	Benefits Office *Phone:* (212) 523-5193	*Website:* www.prudential.com
Short and Long Term Disability	Liberty Mutual *Phone:* (800) 530-6503	
Business Travel Accident Insurance	American International Life Assurance Company of New York C/O Kaye Insurance Plan Administrators Benefits Office *Phone:* (212) 523-5193	
Flexible Spending Accounts	Ceridian FlexServ FSA Claims and Customer Service Center *Phone:* (877) 799-8820	*Website:* www.ceridianfsa.com

The following pages provide administrative information about each of the Beth Israel Medical Center, St. Luke's-Roosevelt Hospital Center and Long Island College Hospital plans.

Medical

HIP 55 Water Street New York, NY 10041	**Plan Numbers:** 100 9214 (BI) 100 9648 (SLR)
Empire BlueCross BlueShield 165 Broadway New York, NY 10006	**Plan Numbers:** 265346 (BI/SLR) 265346 (LICH)

Prescription

Medco Health Solutions 100 Parsons Pond Drive Franklin Lakes, NJ 07417	**Plan Number:** RX4CHP1

Dental

Empire BlueCross BlueShield 165 Broadway New York, NY 10006	**Plan Numbers:** 265346 (BI/SLR) 265346 (LICH)
Guardian P.O. Box 2459 Spokane, WA 99210-2459	**Plan Numbers:** 353233 (BI/SLR) 353233 (LICH)

Short-Term Disability / Long-Term Disability

Liberty Mutual 100 Liberty Way Dover, NH 03820-5808	**Plan Number:** 820-092850

Life

The Prudential Insurance Company of America Group Life Claims Division P.O. Box 8517 Philadelphia, PA 19176	**Plan Numbers:** 44941 (BI) 44964 (SLR) 44965 (LICH)

Vision

UnitedHealthcare Vision Liberty 6, Suite 200 6220 Old Dobbin Lane Columbia, MD 21045	**Plan Number:** GMHS

Flexible Spending Account

Ceridian P.O. Box 534134 St. Petersburg, FL 33747-4134	**Plan Numbers:** 101611 (LICH) 101670 (BI) 101671 (SLR)

Business Travel Accident Insurance

American International Life Assurance Company of New York C/O Kaye Insurance Plan Administrators 100 Sunnyside Blvd. Woodbury, NY 11797	**Plan number:** GTP 0008063110

COBRA

Ceridian COBRA National Service Center 3201 34th Street South St. Petersburg, FL 33711	**Plan numbers:** 135565934 (BI) 132997301 (SLR) 111018985 (LICH)

Claims Handling Guide

Benefit Area	Who files claim	Where to get forms	How to file claims	Where to mail claims
Empire BlueCross BlueShield PPO & Empire EPO				
Hospitalization	Provider/Hospital	Hospital claims	Hospital files	Empire BlueCross BlueShield P.O. Box 1407, Church Street Station New York, NY 10008-1407
Medical	Provider/Member	Benefits Office or by calling Empire BCBS	Submit a claim form to Empire for out-of-network services along with applicable receipts	Empire BlueCross BlueShield P.O. Box 1407, Church Street Station New York, NY 10008-1407
HIP				
Hospitalization	Provider/Hospital	Hospital	Hospital files claims	HIP 55 Water Street New York, NY 10041
Medical	Provider/Member	Benefits Office or by calling HIP	Submit a claim form to HIP for out-of- network services along with applicable receipts	HIP 55 Water Street New York, NY 10041
Guardian Dental				
Dental	Provider/Member	Benefits Office	Submit a claim form to Guardian for out-of-network services along with applicable receipts	Guardian Group Dental Claims P.O. Box 2459 Spokane WA 99210-2459
Empire Managed Dental				
Dental	Provider/Member	N/A	Provider files claims	Empire Dental P.O. Box 791 Minneapolis, MN 55440-0791

Claims Handling Guide (Continued)

Benefit Area	Who files claim	Where to get forms	How to file claims	Where to mail claims
Prescription				
Prescription	Pharmacy/Member	Benefits Office or by calling Medco Health Solutions	Submit a claim form to Medco for out-of-network services along with applicable receipts	Medco Health Solutions P.O. Box 14711 Lexington, KY 40512
UnitedHealthcare Vision				
Vision Care	Provider/Member	N/A	Submit itemized receipts, with the participant's social security number and patient's date of birth	UnitedHealthcare Vision P.O. 30978 Salt Lake City, UT 84130
Flexible Spending Account				
Dependent Care FSA and Health Care FSA	Member	Benefits Office	Submit a claim form to Ceridian	FSA Claim Administration P.O. Box 534134 St. Petersburg, FL 33747-4134 or fax claim to: (877) 488-6464
Group Life and AD&D Insurance				
Life and AD&D insurance	Beneficiary	Benefits Office	Provide death certificate with original seal and death claim	The Prudential Life Insurance Company of America Group Life Claims Division \.O. Box 8517 Philadelphia, PA 19176
Short Term Disability				
Short Term Disability	Member	Benefits Office	Complete a leave of absence form Call Liberty to initiate claim: (800) 530-6503	Liberty Mutual P.O. Box 1525 Dover, NH 03821-1525
Long Term Disability				
Long Term Disability	N/A – Long Term Disability is a continuation of Short Term Disability	N/A – Long Term Disability is a continuation of Short Term Disability	Long Term Disability claim is processed by Liberty when disability period exceeds 180 days	N/A
Business Travel Accident Insurance				
Business Travel Accident Insurance	Employer	Benefits Office	Written proof of loss must be sent.	American International Life Assurance Company of New York C/O Kaye Insurance Plan Administrators 100 Sunnyside Blvd. Woodbury, NY 11797

Claims Procedure

Health Benefit Claims

Timing of Initial Claim Determinations

Timely Claim Filing

Empire must receive your medical and/or dental claims within 18 months from the dates of service. Claims received after that time will not be considered under the plan.

Medco Health Solutions must rececive your prescription claim within 12 months from the dates of service. Claims received after that time will not be considered under the plan.

Guardian must receive your dental claims within 24 months from the dates of service. Claims received after that time will not be considered under the plan.

UnitedHealthcare must receive your out-or-network claim within 12 months from the dates of service. Claims received after that time will not be considered under the plan.

If You Receive an Overpayment of Benefits

If you receive benefits that either should not have been paid, or are more than should have been paid, you must return any overpayment to Empire within 60 days of receiving it. Overpayments include:

- Payment for a service not covered by the plan.
- Payment for a person not covered by the plan.
- Payment that exceeds the amount due under your plan.
- Duplicate payments for the same services.

Pre-Service Claims (Precertification)

A “pre-service claim” is any claim for a benefit under the health plan that must be approved (in whole or in part) before you can receive the medical care.

If you file a pre-service claim, the relevant health care provider will notify you of the benefit determination no later than 15 days after receipt of your claim. If the relevant health care provider determines that an extension of time is necessary due to matters beyond the control of the health plan, this period may extended for up to an additional 15 days. You will be notified of the extension before the initial 15-day period expires, and the notice will describe the circumstances requiring the extension and inform you of the date by which the relevant health care provider expects to make a decision on your claim. If the extension is necessary because you failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have 45 days from your receipt of the notice to provide the requested information.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of (i) the date on which you respond to the relevant health care provider's request for additional information, or (ii) expiration o the 45-day period commencing on the date you are notified that you must provide the requested additional information.

If you (or your authorized representative) fail to follow the health plan's procedures for filing a pre-service claim, you (or your representative) will be notified of the failure and the proper procedures to follow. You (or your authorized representative) will be provided with this notification within 5 days following the procedural failure. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the relevant health care provider and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested.

Post-Service Claims

A “post-service claim” is any claim that is not deemed a “pre-service claim” (as defined above). These are claims for which you do not need advance approval before receiving medical care.

If you file a post-service claim, the relevant health care provider will notify you of an adverse benefit determination no later than 30 days after receipt of your claim. If the relevant health care provider determines that an extension of time is necessary due to matters beyond the control of the health plan, this period may be extended for up to an additional 15 days. You will be notified of the extension before the initial 30-day period expires, and the notice will describe the circumstances requiring the extension and inform you of the date by which the relevant health care provider expects to make a decision on your claim. If the extension is necessary because you failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have 45 days from your receipt of the notice to provide the requested information.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of (i) the date on which you respond to the relevant health care provider's request for additional information, or (ii) expiration of the 45-day period commencing on the date you are notified that you must provide the requested additional information.

Urgent Care Claims

An "urgent care claim" is a claim for medical care or treatment with respect to which application of the time periods for making non-urgent care claim decisions (as described above): (i) could seriously jeopardize your life, health, or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the treatment that you are requesting in your claim.

If you file an urgent care claim, the relevant health care provider will notify you of the benefit determination as soon as possible, taking into account medical exigencies, but no later than 72 hours after receipt of your claim. However, if you fail to provide sufficient information in order for the relevant health care provider to determine whether, or to what extent, benefits are covered or payable under the health plan, the relevant health care provider will notify you within 24 hours after receiving your claim of the specific information necessary to complete the claim. You will then have a period of no less than 48 hours, taking into account the circumstances, to provide the specified information to the relevant health care provider. The relevant health care provider will then notify you of the benefit determination no later than 48 hours after the earlier of (i) the relevant health care provider's receipt of the specified information, or (ii) the end of the period afforded to you to provide the specified additional information.

If you (or your authorized representative) fail to follow the health plan's procedures for filing an urgent care claim, you (or your authorized representative) will be notified of the failure and the proper procedures to follow. You (or your authorized representative) will be provided with this notification within 24 hours following the procedural failure. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the relevant health care provider and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested.

Concurrent Care Claims

A concurrent care claim is a claim relating to an ongoing course of treatment approved by the health plan, which is provided to you over a period of time or for a specified number of treatments.

If you are receiving concurrent care benefits and the relevant health care provider decides to reduce or terminate the course of treatment before the end of the previously approved treatment period (other than by health plan amendment or termination), you will be notified of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you ample time to request a review of the decision and obtain a determination upon review before the benefit is reduced or terminated.

If you make a claim to extend a course of treatment beyond the approved period of time or number of treatments, and the claim involves urgent care, the relevant health care provider will make a determination on your claim as soon as possible, taking into account medical exigencies, and will notify you of the decision within 24 hours after receipt of your claim, provided that your claim was filed at least 24 hours before expiration of the previously approved period of time or number of treatments.

Notice of Initial Claim Determinations

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, the relevant health care provider will notify you (or your authorized representative) of the benefit determination in writing or electronically within the time periods described above. This notification will include:

- the specific reason(s) for the denial or other adverse benefit determination;
- references to the specific health plan provisions on which the determination was based;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary; and
- a description of the health plan s review procedures and the applicable time limits.

If your claim involves urgent care, the notification will also include a description of the expedited review process that applies to those types of claims. In addition, for urgent care claims, the notification may be provided to you orally within the 72-hour time frame described above, but written or electronic notification will also be furnished to you within 3 days of the oral notification.

Finally, you will be advised of the steps which should be taken to appeal the denial of benefits to the relevant health care provide.

Requests for Review of Claim Denials and Other Adverse Benefit Determinations

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, you have the right to request a review of that determination by the relevant health care carrier. In order to do so, you (or your authorized representative) must, within 180 days after you receive the notice of denial, submit your written request for review to the relevant health care carrier.
In connection with your request for review, you (or your authorized representative) may submit written comments,

documents, records or other information relating to your claim. In addition, you will be provided, upon your written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. The review will take into account all comments, documents, records and other information that you submit relating to your claim.

As noted, if your claim involves urgent care, an expedited review process will be available to you, pursuant to which you may request an expedited review either orally or in writing. In addition, all necessary information, including the relevant health care provider's determination on review, will be exchanged between the health plan and you by telephone, fax or other available expeditious methods. You will receive a detailed description of the expedited review process in the notice of claim denial that is sent to you.

Timing of Benefit Determinations on Review

Pre-Service Claims

If you request a review of a pre-service claim, you will be notified of the decision on review no later than 30 days after the health plan receives your request for review.

Post-Service Claims

If you request a review of a post-service claim, you will be notified of the decision on review no later than 60 days after the health plan receives your request for review.

Urgent Care Claims

If you request a review of an urgent care claim, you will be notified of the decision on review no later than 72 hours after the relevant health care provide receives your request for review.

Concurrent Care Claims

If you request a review of a decision denying your request to extend a course of treatment, you will be notified of the decision in accordance with the above rules for pre-service, post-service or urgent care claims, as applicable.

If you request a review of a decision to reduce or terminate a course of treatment before the end of the previously-approved period or number of treatments, you will receive a decision on review before the benefit is reduced or terminated.

Notice of Benefit Determinations on Review

You will be notified in writing or electronically of the determination on review. If an adverse benefit determination is made on review, the notice will include the specific reasons(s) for the determination, with references to the specific health plan provisions on which it is based. All decisions on review are final, conclusive and binding on all parties.

Disability Benefit Claims

If your claim for disability benefits ("Disability Benefits") under STD coverage or LTD coverage is denied, in whole or in part, the relevant provider will provide you with a written explanation or electronic notification of the reasons for the denial within 45 days from the date the claim is received. In addition to a description of the reason for the denial, you will be advised of the specific provisions of the disability plan on which the denial is based. You will be instructed as to exactly what, if any, additional information or material is needed to process your claim and why it is needed and, if an internal rule, guideline, protocol or other similar criterion is used in making the adverse determination, you will be provided with a copy of such internal rule, guideline, protocol or similar criterion or, the written explanation or electronic notification will indicate that such rule, guideline, protocol or criterion was relied upon in making the adverse determination and that a copy is available at no cost upon your request. Finally, you will be advised of the procedures which should be taken to appeal the denial of Disability Benefits to the relevant provider, and time limits applicable to such procedures including a statement about your right to bring suit pursuant to Section 502(a) of ERISA following a denial of the claim on review.

The relevant provider may determine that for reasons beyond the control of the relevant provider, it requires more than 45 days to process your claim and make a determination. In such a case, a notice of extension will be mailed to you within 45 days from the date your claim is received and the final decision will be sent to you within 75 days from the date your claim is received. If prior to the end of the 75 days period the relevant provider determines that for reasons beyond the control of the relevant provider it will require more than 75 days to process your claim and make a determination, the period for making the determination may be extended for up to an additional 30 days. In such a case, a notice of extension will be mailed to you within 75 days from the date your claim is received.

Any notice of extension shall: (i) indicate the special circumstances which required the extension of time; (ii) specifically explain the standards to which entitlement to a Disability Benefit is based; (iii) explain any unresolved issues that prevent a decision on the claim; (iv) indicate what additional information is needed to resolve those issues and (v) indicate the date as of which the relevant provider expects to render a decision. If additional information is needed, you will be given at least 45 days within which to provide the specified information. In the event the relevant provider requests an extension due to your failure to provide necessary information, the time period required for the relevant provider to make the determination will be tolled from the date on which notice of extension is sent to you until the earlier of (i) the date you respond to the notice, or (ii) expiration of the 45-day period commencing on the date you are notified that you must provide the requested additional information.

If your claim is denied, notice of the denial will be sent to you no more than 105 days after the date your claim is received.

You will have 180 days from the date you receive the notice of the denial of your claim to file a request for an appeal of the denial of Disability Benefits. Such request must be made in writing to the relevant provider. You may submit written comments, documents, records and other information relating to the claim and, upon written request and free of charge, you may review documents, records and other information relevant to the claim. A document, record or other information is considered "relevant" to a claim for this purpose if it (i) was relied upon in making the Disability Benefit determination, (ii) was submitted, considered, or generated in the course of making the Disability Benefit determination, without regard to whether such document, record or other information was relied upon in making the Disability Benefit determination, or (iii) demonstrates compliance with the administrative process and safeguards required by law when making the Disability Benefit determination.

In deciding an appeal of any adverse Disability Benefit determination that is based in whole or in part on a medical judgment, the relevant provider 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 is neither an individual who was consulted in connection with the initial adverse determination nor the subordinate of such individual. The decision of the relevant provider on an appeal of a claim which involved medical judgment shall identify the medical or vocational experts whose advice was obtained, whether or not the relevant provider relied on the advice in making its decision.

You will be entitled to a new decision on appeal. Accordingly, in no event will any decision on appeal be decided by the same individual who rendered the initial adverse determination or be a subordinate of such individual. The decision on appeal will be made without giving any weight to the initial adverse determination.

Unless the relevant provider determines that special circumstances require an extension of time for processing the decision, such decision shall not be made later than 45 days after the relevant provider's receipt of a request for review. If an extension of time for review is required, a decision shall be rendered as soon as possible, but not later than 90 days after receipt of a request for review. Written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the relevant provider expects to render a determination on review. If the reason the relevant provider requires an extension is your failure to provide necessary information, the time period required for the relevant provider to make a determination will be tolled from the date on which notice of the extension is sent to you until the earlier of (i) the date you respond to the request for additional information, or (ii) expiration of the 45-day period commencing on the date you are notified that you must provide the requested additional information.

The decision on review shall be made in writing or electronic notification and shall include the specific reasons for the decision and refer to the specific provisions of the disability plan on which the decision is based. You will also be entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. You will also be provided with a statement describing any voluntary appeal procedures offered by the disability plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under Section 502(a) of ERISA. If an internal rule, guideline, protocol or similar criterion was relief upon in making the adverse determination, you shall receive a copy of any such rule, guideline, protocol or similar criterion or, the notice will indicate that such rule, guideline, protocol or criterion was relied upon in making the adverse determination and that a copy is available at no cost upon your request. All interpretations, determinations and decisions of the relevant provider with respect to any claim shall be made by the relevant provider, in its sole discretion based on the disability plan documents and shall be final, conclusive and binding.

Other Benefit Claims

You will be notified of the acceptance or denial of your claim for benefits within 90 days from the date the relevant provider receives your claim. In some cases, your request may take more time to review and an additional processing period of up to 90 days may be required. If that happens, you will be notified in writing. The written notice of extension will indicate the special circumstances requiring the extension of time and the date by which the relevant provider expects to make a determination with respect to the claim.

If your claim is wholly or partially denied, or any other adverse benefit determination is made with respect to your claim, the relevant provider will furnish you with a written notice of this denial. This written notice will be provided to you within a reasonable period of time (generally 90 days) after the receipt of your claim by the relevant provider. The written notice will contain the following information: (i) the specific reason or reasons for the denial; (ii) specific reference to those plan provisions on which the denial is based; (iii) a description of any additional information or material necessary to correct your claim and an explanation of why such material or information is necessary; and (iv) a description of the plan's review procedures and the applicable time limits, as well as a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If notice of the denial of a claim is not furnished to you in accordance with the above within a reasonable period of time, your claim will be deemed denied. You will then be permitted to proceed to the review stage described in the following paragraphs.

If your claim has been denied, or any other adverse benefit determination is made with respect to your claim, and you wish to submit your claim for review, you must file your claim for review, in writing, with the relevant provider. You must file the claim for review no later than 60 days after you have received written notification of the denial of your claim for benefits (or, if none was provided, no later than 60 days after the deemed denial of your claim). In connection with the request for review, you (or your duly authorized representative) may submit to the relevant provider written comments, documents, records, and other information relating to the claim. In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim. The review by the relevant provider will take into account all comments, documents, records, and other information you submit relating to the claim.

The relevant provider will make a final written decision on a claim review, in most cases, within 60 days after receiving your written claim for review. In some cases, your claim may take more time to review, and an additional processing period of up to 60 days may be required. If that happens, you will be notified in writing. The written notice of extension will indicate the special circumstances requiring the extension of time and the date by which the relevant provider expects to make a determination with respect to the claim. If the extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of (i) date on which you respond to the plan's request for information, or (ii) expiration of the 45-day period commencing on the date you are notified that you must provide the requested additional information.

The relevant provider's decision on your claim for review will be communicated to you in writing. If an adverse benefit determination is made, this notice will include (i) the specific reason(s) for the adverse benefit determination, with references to the specific plan provisions on which the determination is based; (ii) a statement that you are entitled to receive upon request and free of charge, reasonable access to (and copies of) all documents, records and other information relevant to the claim; and (iii) a statement of your right to bring a civil action under Section 502(a) of ERISA. All interpretations, determinations and decisions of the relevant provider with respect to any claim or any matter relating to the plan will be made in their sole discretion based on the plan documents and will be deemed final, conclusive and binding.

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