ASSOCIATE BENEFITS PROGRAM
2017 SUMMARY PLAN DESCRIPTION

Montefiore

INTRODUCTION

As an associate of Montefiore Health System (also referred to as "Montefiore"), you enjoy the advantages of an excellent benefits program. The Montefiore Associate Benefits Program provides some very valuable advantages to you and your family, including:

- The *flexibility* to choose from a wide range of benefit options that best meet your individual needs
- The *opportunity* to change your choices once each year as your needs for coverage change

  Plus

- Valuable tax-savings opportunities.

This is a Summary Plan Description (SPD) of the plans that make up your Montefiore Associate Benefits Program. It is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This SPD provides a description of the plans in effect on January 1, 2017. It explains when you become eligible, what benefits the plans pay, any benefit limitations that apply, how to file claims and where to obtain additional information. If you have questions about your benefits, contact Montefiore's HR-Benefits Office.

This SPD supersedes all earlier SPDs for the Montefiore Associate Benefits Program. Prior Summary Plan Descriptions and updates described in the fall annual election materials should be discarded.

Information about each of the benefits that make up the Montefiore Associate Benefits Program – and how the Program works – can be found in the following sections.

Information regarding the following plans is available through these links:

- **Accidental Death & Dismemberment Insurance Certificate**
- **Business Travel Accident (BTA) Insurance**
- Disability
  - STD
    - **Executive**
    - **Associate**
  - LTD (**LTD Certificate Rider**)
    - **Executive**
    - **Associate**
- **Life Insurance Certificate**

Montefiore complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. See page 72 for more details.

If you (and/or your family members) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 51 for more details.

ELIGIBILITY AND ENROLLMENT

The Montefiore Associate Benefits Program offers valuable protection to you and your family members. To utilize this coverage, it is important to know who is eligible and how to enroll.

What the Eligibility and Enrollment Section Includes

Glossary of Key Terms

1199 – 1199SEIU United Healthcare Workers East.

Associate – A full-time or part-time employee of Montefiore.

Claims Administrator – The company contracted by Montefiore to supervise the processing of claims and administration of the Montefiore Associate Benefits Program.

Family Members – Your spouse (if legally married) and children of you or your spouse whom you can cover through December 31 of the year the child reaches age 26 – or a child who is disabled prior to that age. With respect to medical, dental and vision benefits, "Family Member" includes an enrolled Associate's domestic partner if his or her domestic partner was enrolled in such benefits on April 26, 2013 and for whom coverage under the Montefiore Associate Benefits Program has not ended. No domestic partners may be enrolled in the Montefiore Associate Benefits Program after April 26, 2013.

Full-time Associate – An associate of Montefiore who is regularly scheduled to work 100% of a full-time schedule.

Montefiore's HR-Benefits Office – Contact the HR-Benefits Office by email at **montebenefits@montefiore.org** or by calling **914.349.8531**. The mailing address is:

HR-Benefits Office
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490

NYSNA – The New York State Nurses Association.

Part-time Associate – An associate of Montefiore who is regularly scheduled to work less than 100% of a full-time schedule. A regular part-time associate does not include as reported, contingent, session or per diem associates. However, to be eligible for the benefits described in this SPD, a part-time associate must be regularly scheduled to work at least 50% of a full-time schedule.

Qualified Domestic Partner – An individual of the same sex with whom you reside, provided you and that individual:

- Are registered as domestic partners in accordance with the highest form of legally recognized relationship available in your state of legal residence.
- Are unable to marry because of laws prohibiting marriage to persons of the same sex in the state of your legal residence.

Spouse – The individual to whom you are legally married according to civil or common law in your state of residence.

Temporary Associate – A full-time or part-time associate of Montefiore who is hired and employed to work for a definite period of time of limited duration that does not exceed six months.

Eligibility for Associate Benefits

You are eligible to enroll in the Montefiore Associate Benefits Program

- if you are a regular or temporary associate of Montefiore or Montefiore Information Technology and work at least 50% of a full-time schedule
- If you are a regular or temporary associate of Montefiore Mount Vernon Hospital, Montefiore New Rochelle Hospital or Schaffer Extended Care Center and work at least 50% of a full-time schedule.

Eligible individuals include associates whose collective bargaining agreement provides for coverage under the Montefiore Associate Benefits Program. In determining your eligibility, the Plan Administrator will rely on the worker classification assigned to you by Montefiore as determined under Montefiore's Human Resources Policy and Procedure Manual.

The following associates are *not* eligible for the Montefiore Associate Benefits Program:

- Registered nurses whose position is covered by a collective bargaining agreement with the NYSNA or 1199
- Associates whose position is covered by a collective bargaining agreement with 1199, Local 445 or Local 30
- House Staff Officers
- Security guards whose position is covered by a collective bargaining agreement with the Special and Superior Officers Benevolent Association (SSOBA)
- Leased employees
- Independent contractors

  and

- Any other associate who is not treated as an employee for payroll purposes even if a court or administrative agency determines that such an individual is an employee rather than an independent contractor.

Family Members

Your family members are also eligible for coverage under the Montefiore Associate Benefits Program.

FOR HEALTHCARE, GROUP LEGAL SERVICES, DEPENDENT LIFE AND AD&D INSURANCE

Eligible family members include your spouse and children of you or your spouse, whom you can cover through December 31 of the year they reach age 26. With respect to medical, dental and vision benefits, "Family Member" includes an enrolled Associate's domestic partner if his or her domestic partner was enrolled in such benefits on April 26, 2013 and for whom coverage under the Montefiore Associate Benefits Program has not ended. No domestic partners may be enrolled in the Montefiore Associate Benefits Program after April 26, 2013.

Stepchildren, children of an enrolled domestic partner, legally adopted children, and children for whom you are legal guardian are also eligible for coverage, as long as they meet the age requirement.

Coverage can be continued beyond the ages shown above for an eligible child who while covered as your dependent under the Montefiore Associate Benefits Program, becomes disabled – as determined by the Claims Administrator. You will initially be required to provide a physician's statement certifying the child's handicap and provide periodic proof thereafter, as requested by the Claims Administrator and/or Dental Health Maintenance Organization (DHMO). Coverage will continue while you remain covered by Montefiore benefits for as long as the child remains disabled. To apply for this continuing coverage, you must notify Montefiore's HR-Benefits Office in writing on the appropriate forms at least 30 days before the child's coverage would otherwise end.

Your Cost for Coverage

The following table shows each of the benefit options available to you and whether or not you contribute toward the cost of coverage. If you are an eligible part-time associate, your share of the cost is pro-rated based on your schedule as compared to a full-time schedule.

Benefit Area	Cost of Coverage
Medical	You and Montefiore share the cost of coverage.
· MonteCare EPO	Your MonteCare EPO contributions are based on your salary, if you are a full-time or part-time associate, whether you use tobacco and whether you elect single or family coverage.
· MonteCare PPO	Your MonteCare PPO contributions are also based on your salary, if you are a full-time or part-time associate, whether you use tobacco and whether you elect single or family coverage ***plus*** the difference in cost between MonteCare EPO and MonteCare PPO coverage.
Vision	You pay the full cost of coverage.
Dental	If you elect Dental coverage during your first year* at Montefiore, you pay the full cost of coverage.
· Preventive & Diagnostic Dental Care Only	After one year, Montefiore pays the full cost of coverage.
· Cigna DPPO Option	After one year, you and Montefiore share the cost of coverage.
· Cigna Enhanced DPPO	After one year, you and Montefiore share the cost of coverage *plus* you pay the difference in cost between the Cigna DPPO and the Enhanced Plan.
· Cigna Dental Health Maintenance Organization (DHMO)	After one year, you continue to pay the full cost of DHMO coverage.
Flexible Spending Accounts	You make all of the contributions necessary to fund these accounts.
Basic Life Insurance	If you elect Basic Life Insurance coverage during your first year* at Montefiore, you pay the full cost. After one year, Montefiore pays for coverage equal to one times your annual base salary – up to $250,000. If your annual base salary is greater than $50,000, you can opt down to $50,000 to avoid imputed income.
Basic AD&D Insurance	If you elect Basic AD&D Insurance coverage during your first year* at Montefiore, you pay the full cost. After one year, Montefiore pays for coverage equal to one times your annual base salary – up to $250,000.
Business Travel Accident (BTA) Insurance	Montefiore pays the full cost of BTA coverage
Supplemental Life Insurance, Supplemental AD&D Insurance, Dependent Life Insurance, Dependent AD&D Insurance, Group Legal Services	You pay the full cost of coverage.

* Service credit for benefits purposes includes:

- Continuous service in the Albert Einstein College of Medicine clinical teaching program if it immediately precedes your employment at Montefiore
- Periods of continuous regular or temporary employment in an ineligible class (e.g., associates covered by a collective bargaining agreement with 1199 or the NYSNA).

Periods of employment as a contingent or per diem associate are not counted as part of your first year of employment.

Contributions

Benefit Contributions are deducted bi-weekly.

Any contributions you make for Basic and Supplemental Life Insurance, Basic and Supplemental AD&D Insurance, Dependent Life Insurance, Dependent AD&D Insurance and Group Legal Services coverage are made with after-tax dollars. After-tax dollars are deducted from your pay after all applicable taxes have been determined and withheld.

Any contributions for Medical, Vision, Dental and Flexible Spending Accounts are made with *before-tax dollars*.

Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld – and in most states, including New York – before state and local taxes are withheld too. This gives your contributions a special tax advantage and lowers the actual cost to you.

Although before-tax contributions reduce your taxable income, they generally will not affect other benefits related to your income. By making before-tax contributions, you may pay less in Social Security taxes, which could lower your Social Security benefits at retirement or in case of disability. However, any reduction in Social Security benefits should be minimal.

If you elect Medical, Vision or Dental coverage for a qualified domestic partner, the difference between the cost for single and family coverage will be included in your taxable income to calculate withholding taxes each pay period. This amount is subject to federal, state and city income taxes and Social Security and Medicare tax – *unless your qualified domestic partner is a dependent for federal income tax purposes.* If your qualified domestic partner is your dependent, you must provide proof to the Plan Administrator.

How to Enroll

When you first begin at Montefiore and each year during the Fall Annual Benefits Election Period, you have the opportunity to elect your benefit options.

You enroll online at Montefiore's Enrollment Website – **www.montebenefits.com**. Or, you can call the Benefits Enrollment Call Center **888.860.6166** Monday through Friday between 8am and 8pm EST. An enrollment specialist will help you enroll.

If you have questions about:

- ***The enrollment process or the Enrollment Website***, click on the live Chat icon on the top, right toolbar after you log in (Monday through Friday between 8am and 8pm EST).
- ***Your benefits***, call the HR-Benefits Office at **914.349.8531** or email **montebenefits@montefiore.org**.

Enroll Online

Log on to **www.montebenefits.com** using your username and password.

- **Verify Your Personal Information and Dependent Eligibility.**
  - You are required to enter a Primary Contact name and telephone number. It is important for Montefiore to know who to contact on your behalf in the event of an emergency.
  - Enter your family member information. You ***must*** include each dependent's name, date of birth and Social Security Number.
  - List your beneficiary designation(s) information for life insurance coverage. Be sure you have each beneficiary's name, date of birth and Social Security Number.

Important
Providing dependent and beneficiary information does not automatically enroll a dependent in coverage or designate a beneficiary. That's accomplished through the benefits selection process.

If you need to make any changes to your personal information, please email the HR-Benefits Office at montebenefits@montefiore.org.

- **Select Your Benefits.**
  - When you enroll, indicate whether you use tobacco. If you have used tobacco products and answer "Yes" to the tobacco user question(s), you will be assessed a higher tobacco user premium. This means your medical premium will be 20% higher than a non-tobacco user's premium rate. A non-tobacco user has not smoked, chewed or in any other manner used tobacco products of any kind during:
    - the 12 months immediately before October 1st of the year in which you enroll *for* Supplemental Life Insurance
    - The 6 months immediately before December 31st of the year in which you enroll for Medical coverage or if you are a tobacco user and intend to arrange for a consultation with OHS/Referral for Free Nicotine Replacement Therapy by December 31st of the year in which you enroll.

      If you do not answer the tobacco use question, you will pay the higher tobacco user premium surcharge for Medical and Supplemental Life Insurance coverage – even if you are not a tobacco user.
  - Enroll family members for healthcare coverage.
  - You must make a Healthcare and/or Dependent Care Flexible Spending Account election each year if you want either or both of these accounts.
  - Designate a beneficiary for your Life and AD&D Insurance.

DEPENDENT VERIFICATION

If you elect family healthcare coverage, you must submit verification of your family member's status with a copy of the following documentation:

- Marriage License, the first page of your most recent tax return (1040 form) or Affidavit of Domestic Partnership (if marriage between same sex partners is not recognized in your legal state of residence
- Birth Certificate, Affidavit of Dependency, final Adoption Decree or Court Order.

Please send the documents via email, fax or mail to:

- Email: **mmcdepverify@winstonbenefits.com**
- Fax: **732.903.1166**
- Mail: Winston Financial Services
  Montefiore Dependent Audit
  PO Box 430
  Manasquan, NJ 08736

If you are enrolled in the DHMO and you do not enroll a dependent (age five or older) within 31 days of the date he/she first becomes eligible, DHMO benefits during the first 12 months of coverage will be limited to preventive and diagnostic care, X-rays and pathology, and treatment of accidental injuries sustained while a DHMO participant.

You should notify Montefiore's HR-Benefits Office, in writing, within 30 days if a covered family member no longer qualifies for coverage. That way, you can, if you wish, arrange for COBRA coverage for Medical, Vision and Dental benefits. If you fail to notify Montefiore's HR-Benefits Office in writing, your contributions will continue to be based on the family rate even if you have no other covered dependents.

Default Coverage

If you are a newly eligible associate and do ***not*** enroll within 30 days after you become eligible, you will default to the following coverages and will not be able to make any changes during the year, unless you have a qualified change in status:

- MonteCare EPO – medical coverage for yourself only
- Preventive & Diagnostic Dental Care – single dental coverage for preventive and diagnostic care only
- Basic Life Insurance and Basic AD&D Insurance each equal to one times your annual base salary (up to a maximum of $250,000)
- BTA and Basic Long-term Disability
- No Vision, Supplemental Life Insurance, Supplemental AD&D Insurance, Dependent Life Insurance,

Dependent AD&D Insurance, Group Legal Services or Flexible Spending Accounts

HIPAA Special Enrollment Rights

You may request a special enrollment under the following circumstances:

- Within 30-days of the date:
  - You or a family member loses other group health plan coverage (such as a spouse's plan)
  - You acquire a new family member through marriage, birth, adoption or legal guardianship
- Within 60-days of the date, you or a family member:
  - Are no longer eligible for coverage under the Children's Health Insurance Program (CHIP) or Medicaid
  - Becomes eligible for premium assistance under the State's Children's Health Insurance Program (CHIP) or Medicaid.

When Coverage Begins

For:	This is when coverage begins if you are a:	
	A regular full-time or eligible part-time associate	**A temporary full-time or eligible part-time associate**
· Healthcare · Flexible Spending Accounts · Basic and Supplemental Life Insurance*, Dependent Life · Basic and Supplemental AD&D Insurance, Dependent AD&D · Group Legal Services · Long Term Disability	The first day of the month coincident with or after your first day of employment**	The first day of the month coincident with or after you complete three months of employment**
· Business Travel Accident (BTA) Insurance	Your first day of employment	

* If you elect Supplemental Life Insurance coverage that is more than three times your pay, you must provide evidence of insurability to the insurance company. Coverage exceeding three times pay and contributions for that coverage will not begin until you receive written approval from the insurance company.

**Service credit for benefits purposes includes:

- Continuous service in the Albert Einstein College of Medicine clinical teaching program if it immediately precedes your employment at Montefiore, and service with Yeshiva University or the Albert Einstein College of Medicine for employees who transferred employment between April 20, 2015 and June 30, 2016 from Yeshiva University or the Albert Einstein College of Medicine directly to Montefiore or Montefiore IT
- Periods of continuous regular or temporary employment in an ineligible class (e.g., associates covered by collective bargaining agreement with 1199 or the NYSNA)

Note: Periods of employment as a contingent or per diem associate are not counted as part of your first year of employment.

Coverage for your enrolled family members begins when your coverage begins provided you have enrolled them within 30 days after they first become eligible. Otherwise, their coverage will not begin until the January 1 after the next fall annual election period in which you enroll them.

If a family member (other than a newborn child) is hospitalized on the day coverage is to begin, coverage for that member won't begin until the confinement ends.

Benefit elections made during the fall annual election period become effective on the following January 1st.

Changing Your Enrollment Decisions during the Year

Internal Revenue Service (IRS) rules restrict your ability to change your Montefiore Associate Benefits Program enrollment decisions at any time other than during the fall annual election period, unless you experience a qualified change in status. Qualified status changes include:

- Your marriage, divorce, legal separation, or annulment
- Establishment or termination of a qualified domestic partnership
- Birth, adoption or legal guardianship of a dependent child
- Death of a family member
- Failure of a child to qualify as a dependent (i.e., he or she reaches the maximum age for coverage or is no longer handicapped)
- Change in your spouse's or qualified domestic partner's employment (either starts a new job or terminates employment) or involuntary loss of insurance coverage under another group plan
- Change in your or your spouse's or qualified domestic partner's position or schedule that makes you ineligible for coverage
- You or your dependent lose coverage under any group health coverage sponsored by a governmental or educational institution.
- Change from a non-participating part-time to an eligible associate
- Change from a full-time to an eligible part-time associate
- Geographic relocation that changes your DHMO membership options
- Strike or lockout involving you, your spouse, qualified domestic partner or dependent
- Commencement or return from an unpaid leave of absence by you, your spouse, qualified domestic partner or dependent
- A change resulting from the issuance of a court or administrative order which requires benefit coverage
- Qualifying for annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day following the termination of your benefit coverage under the Plan

- A change that corresponds with changes made by you or your dependent under another employer plan in the following circumstances:
  - If the annual enrollment period under the other employer plan occurs at a different time of year than Montefiore's annual enrollment and the other employer plan has a period of coverage that is different than the period of coverage provided under the Plan; or
  - If the other employer plan allows you or your dependent to change elections due to the reasons described above.

If you experience a qualified change in status, you can modify your Montefiore Associate Benefits Program coverage, provided:

- You notify Montefiore's HR-Benefits Office in writing within 30 days of the change in status, otherwise you will have to wait until the next fall annual election period to modify your coverage and/or to add newly eligible family members
- You furnish appropriate documentation – i.e., a marriage certificate, birth certificate, etc.

  and
- The adjustment you make is consistent with the status change.

Any change in coverage will generally take effect as of the date of the status change. However, those coverage changes which require approval by an insurance company (for example, electing or increasing the amount of your Life Insurance, or electing or increasing Dependent Life Insurance more than 30 days after a family member first becomes eligible) will not go into effect until you receive written notification from the insurance company that your application has been approved. Your contributions will be deducted bi-weekly after Montefiore's HR-Benefits Office has been notified that the new coverage is effective.

Change in Marital Status • Marriage or Establishment of a Qualified Domestic Partnership • Legal Separation, Divorce or Termination of a Domestic Partnership	• Medical, Dental and Vision – elect or change coverage, change option • Life and AD&D Insurance – elect or change coverage • Healthcare FSA – establish an account or increase contributions • Dependent Care FSA – establish an account or change contributions
Change in Family Status • Birth, Adoption, or Legal Guardianship • Death of a Family Member	• Medical, Dental and Vision – elect or change coverage, same option • Life and AD&D Insurance – elect or change coverage • Healthcare FSA – establish an account or increase contributions • Dependent Care FSA – establish an account or change contributions
Change in Employment Status • Your Spouse's or Qualified Domestic Partner's Employment Status Changes • Your Employment Status Changes	• Medical, Dental and Vision – elect or change coverage, change option • Life and AD&D Insurance – elect or change coverage • Healthcare FSA – establish an account or increase contributions • Dependent Care FSA – establish an account or change contributions
Change in Benefits Eligibility	
• You Become Ineligible for Coverage	• Medical, Dental and Vision – Elect COBRA • Life and AD&D Insurance – Convert to direct pay • Healthcare FSA – Make after-tax COBRA contributions for the balance of calendar year • Dependent Care FSA – cancel contributions
• Your Dependent Becomes Ineligible for Coverage	• Medical, Dental and Vision – change coverage, same option, COBRA • Life and AD&D Insurance – change coverage or cancel • FSA – no change
• Your Dependent Becomes Eligible for Coverage	• Medical, Dental and Vision – elect, change coverage, same option • Life and AD&D Insurance – elect or change coverage • Healthcare FSA – establish an account or increase contributions • Dependent Care FSA (no change unless child is under age 13) – establish an account or increase contributions
Relocation to an Area Not Serviced by Your Current DHMO	• Medical – No Change • Dental – Change Option • Vision – No Change • Life and AD&D Insurance and Flexible Spending Accounts – No Change

If Your Pay Is Stopped or Reduced

If your pay is reduced for any reason, your contributions will continue as long as you remain an eligible associate and your salary is sufficient to cover any required contributions. If your salary is not sufficient, you must make arrangements to prepay these premiums unless you are on an approved unpaid leave of absence, in which case you must contact Montefiore's HR-Benefits Office to make arrangements for the payment of your premiums for coverage while on leave. See "Paying for Coverage During a Leave." below.

For example, your pay may be reduced if:

- You exhaust your paid time off benefits
- You switch from a full-time to a part-time schedule

  or

- You are an eligible part-time associate whose schedule is reduced.

Coverage during Approved Leaves of Absence

If you request and are approved for a leave of absence under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be entitled to continue your healthcare coverage provided you satisfy certain requirements. Contact Montefiore's HR-Benefits Office for additional information.

Family and Medical Leave – If you go on an approved FMLA leave you can elect to:

- Continue healthcare coverage for yourself and any enrolled dependents and pay the required contributions

  or

- Suspend coverage during your leave. (If you suspend coverage, you and your dependents will be covered on the day you return to work. Evidence of insurability will not be required.)

If you elect to continue coverage, it will continue for the duration of your leave or until the earlier of the following:

- The date you fail to pay the required contribution within 30 days of its due date

  or

- The date you notify Montefiore that you will not return to work from your leave. (In this case, you will be required to reimburse the Montefiore Associate Benefits Program for premiums advanced by Montefiore on your behalf unless your termination of employment is from reasons beyond your control.)

Military Leave – Healthcare coverage continues for the first six-months of a military leave provided you continue to make the required contributions. If you remain absent for more than six-months, you can elect COBRA continuation coverage. Coverage for your family members remains in effect for six-months after which they can elect COBRA continuation coverage.

Personal Leave – Healthcare coverage continues through the end of the month in which your approved personal leave of absence begins provided you continue to make the required contributions. If you remain absent from work for more than 30 days, you can elect COBRA continuation coverage.

Sabbatical – You can elect to continue your healthcare coverage for up to six months of an approved sabbatical provided you continue to make the required contributions. If you suspend coverage during your leave, you and your dependents will be covered on the day you return to work – without having to provide evidence of insurability.

Paying for Coverage During a Leave

If you elect to continue coverage during an approved leave, you must continue to make the required contributions. You can:

- Pre-pay the entire amount before your leave begins on a before-tax basis

  or

- Make contributions on a monthly basis after your leave begins using after-tax dollars.

HEALTHCARE

Your healthcare benefits are designed to help you pay for most types of healthcare expenses you and your eligible family members may incur.

MEDICAL BENEFITS

Your medical benefits cover a variety of medical services and supplies in and out of the hospital. As an eligible associate, you can select from two options or you can elect no coverage.

This section of your Summary Plan Description describes the benefits provided under MonteCare EPO and MonteCare PPO. Your medical options provide benefits only for covered services and supplies that are medically necessary for the treatment of a covered illness or injury. ***Only those services and supplies specifically listed as covered in this SPD are eligible for reimbursement through your medical benefits.***

What the Medical Section Includes

Glossary of Key Terms

Ambulatory Surgical Center – A public or private facility, licensed and operated according to law, with an organized staff of physicians equipped to perform surgery. Both a physician and a registered nurse (RN) must be on the premises when surgery is performed. Ambulatory care centers do *not* provide services or accommodations for overnight stays.

Annual Out-of-pocket Maximum – The out-of-pocket maximum is the total dollar amount that you have to pay for eligible medical expenses including coinsurance, deductibles and copayments (up to R&C limits) in any calendar year. Once your share of eligible expenses reaches the out-of-pocket maximum, the plan pays 100% of covered services for the remainder of the calendar year. If you are enrolled for family coverage and one family member reaches the individual out-of-pocket maximum amount, the plan will pay 100% of that family member's eligible expenses for the rest of the calendar year. The expenses of any remaining family member or members would then be applied to the family maximum amount. No one individual is required to pay more than the individual out-of-pocket amount.

Birthing Center – A public or private facility, licensed and operated according to law, providing a home-like setting under a controlled environment for the purpose of childbirth.

Bona Fide Medical Emergency – A bona fide medical emergency is a sudden, unexpected and serious illness or injury requiring immediate medical care at the nearest hospital equipped to provide treatment. Examples include heart attack, loss of consciousness, poisoning, appendicitis and convulsions.

Brand Name Drug – A prescription drug with a proprietary name assigned to it by the manufacturer or distributor.

Chiropractic Services – The detection and correction, by manual or mechanical means, of the interference with nerve transmissions caused by the distortion, misalignment or dislocation of the spinal (vertebrae) column.

Coinsurance – The percentage of the cost you pay for covered expenses under medical and dental options, or any other sources of medical and dental payments, such as an employer-sponsored health plan or automobile insurance, once the appropriate deductibles have been satisfied.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal legislation that provides participants who lose healthcare coverage with an opportunity to elect to continue healthcare coverage for a specified period of time by paying the full premium plus a 2% administrative charge.

Copayment – A flat-dollar amount you pay for certain medical services, such as in-network physicians' office visits under MonteCare EPO and MonteCare PPO.

Custodial Care – Room and board and other institutional services provided mainly to aid an aged or physically impaired person in daily living. Activities of daily living include bathing, feeding, administration of oral medicines or other services, which can be provided by someone other than a trained healthcare provider.

Deductible – The annual amount you must pay before benefits for certain covered expenses are paid.

Doctor (or physician) – An individual (other than yourself) holding a degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatric Medicine (DPM) or Doctor of Chiropractic (DC), practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

Elective Medical Admission – Any non-emergency hospital admission, which may be scheduled at the patient's convenience.

Empire Behavioral Health Network – A network of providers who specialize in mental health, alcoholism and substance abuse counseling and treatment.

Empire BlueCross BlueShield (Empire) – The Claims Administrator for the MonteCare EPO and MonteCare PPO. Empire is not the Claims Administrator for Dental, Prescription Drug or Vision benefits, Flexible Spending Accounts or Life Insurance.

Empire BlueCard PPO Network – A national network of doctors, hospitals, laboratories and ancillary healthcare providers who have agreed to charge negotiated rates for their services, which are typically lower than they would otherwise charge.

Experimental/Investigational – A service, supply, or treatment that meets one or more of these conditions:

- It is within the research or experimental/investigational stage, or
- It involves the use of a drug or substance that has not been approved by the United States Food and Drug Administration, by issuance of a New Drug Application or other formal approval, or
- It is not in general use by qualified physicians who are specialists in the field of the illness, or
- It is not of demonstrated value for the diagnosis or treatment of sickness or injury.

Express Scripts – The Claims Administrator for prescription drug benefits.

Formulary – A formulary is a list of medications approved by the U.S. Food and Drug Administration (FDA), including both brand name and generic drugs. Drugs on the formulary are selected by a panel of physicians and pharmacists because they can safely and effectively treat most medical conditions while helping to contain costs. The formulary is reviewed and revised regularly to reflect new prescription drugs and other changes in the market.

Generic Drug – A prescription drug, whether identified by its chemical proprietary or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent.

Healthcare Provider – A physician, nurse, psychologist, psychiatric social worker, psychiatric nurse practitioner, physical, speech or occupational therapist or any other individual providing healthcare services to whom a state has granted a license or certification and permits the billing of their services.

Home Healthcare Agency – A public or private agency or organization licensed and operated according to law, providing medical care and treatment in the patient's home. The agency must be supervised by at least one physician and registered nurse (RN), and be based on policies established by professionals in the field.

Home Hospice – A program of home care approved by a physician for a terminally ill patient with a life expectancy of no more than six months.

Hospice Facility – A public or private organization licensed and operated according to law, primarily engaged in providing palliative, supportive and other related care for terminally ill patients who are not expected to live more than six months. The facility must be staffed by at least one physician, one registered nurse, one social worker, one volunteer and have a volunteer program. A hospice is *not* a facility that is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital – A public or private facility licensed and operated according to law, which provides care and treatment by physicians and nurses to ill or injured people with facilities for diagnosis and major surgery. The facility must be under the supervision of physicians with registered nurses on duty at all times. A hospital does *not* include an institution, or part of one, which is mainly a place for rest, the aged or convalescent care. A hospital under this definition includes treatment facilities for tuberculosis, substance abuse and mental/nervous conditions.

In-network Providers – Physicians and other healthcare providers in the Montefiore Integrated Provider Association (MIPA) or Empire BlueCard PPO Network and Montefiore Network.

Maintenance Care – Services and supplies provided primarily to maintain a level of physical or mental function.

Medically Necessary – Any generally accepted medical service or supply that is:

- Appropriate and necessary for the treatment or diagnosis of a medical condition
- Not primarily for the convenience of the patient or his/her healthcare provider
- Within medical standards or medical practice in the community where services are performed
- The most appropriate treatment, which can safely be provided on an inpatient or outpatient basis.

For hospitalization, medically necessary also means that due to the patient's general health or the severity of the medical condition, treatment cannot be provided on an outpatient basis or in another, less intensive inpatient facility.

For ambulance service, medically necessary means the severity of the individual's medical condition precludes any other means of transportation.

Montefiore Integrated Provider Association (MIPA) – The MIPA is a network of providers established by the Contract Management Organization (CMO) of Montefiore Medical Center. The HR-Benefits Office does not participate in selecting physicians who join the MIPA. The MIPA ensures physicians' credentials. This type of arrangement is called a Preferred Provider Organization (PPO). MIPA physicians must be board-certified or board-eligible and must meet MIPA standards. Montefiore contracts with the MIPA under MonteCare PPO for provider services only. You can call the Montefiore CMO Customer Service Department at **914.377.4400** to determine MIPA providers.

Morbid Obesity – A condition in which:

- An individual weighs at least 100 pounds more than his or her normal body weight or twice the normal weight of a person the same height
- Conventional weight reduction measures have failed
- The excess weight causes a medical condition – e.g., physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

Non-duplication of Benefits – A provision which limits payments from all sources to an amount that MonteCare would have paid had there been no other coverage available.

Nurse – A registered graduate nurse (RN), licensed vocational nurse (LVN), licensed practical nurse (LPN) or nurse practitioner – if licensed in the state where he or she practices for the services provided.

Out-of-network Providers – Physicians and other healthcare providers who are not part of the MIPA or Empire BlueCard PPO Networks.

Participating Pharmacy – A retail pharmacy which has contracted with Express Scripts to provide prescription services.

Reasonable and Customary (R&C) – Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

Separate Admission – Two or more hospital admissions for the same or a related condition that are separated by at least 90 days, *or* which are to treat entirely different illnesses or injuries.

Separate Surgical Procedure – Surgical procedures performed at different operative sessions. If two or more surgical procedures are performed during the same operative session through:

- The same incision, natural body orifice or operative field, medical benefits will cover the R&C charge for the most expensive procedure only, or
- Different incisions, natural body orifice or operative field, medical benefits will cover the R&C charge for the most expensive procedure plus 50% of the combined R&C charges for all other procedures performed.

Skilled Nursing Facility – A public or private facility, licensed and operated according to law, which maintains permanent and full-time accommodations for 10 or more resident patients. It must have a physician or registered nurse or licensed practical nurse on duty at all times. In addition, the facility must keep daily medical records, have transfer arrangements with one or more hospitals and a utilization review plan in effect. A skilled nursing facility must be primarily engaged in providing skilled nursing care for convalescence from an illness or injury and is not a rest home, for custodial care or for the aged.

Special Treatment Facility – A facility with a treatment program approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Subrogation – The right of the Montefiore Benefits Program to recover medical or dental expenses paid to the participant for illness or injuries wrongfully caused by a third party or any illness or injury for which you and/or your family members are eligible to receive reimbursement from a third party.

Subrogation Agreement – A written agreement in which a covered individual agrees to reimburse the appropriate Plan for medical and/or dental benefits resulting from illness or injuries caused by a third party or any illness or injury for which you and/or your family members are eligible to receive reimbursement from a third party. The agreement must be signed by the associate and/or family members, if applicable, before Plan payments are made to reimburse expenses incurred as a result of such illness or injury.

Substance Abuse Treatment Facility – A public or private facility, licensed and operated according to the law, which provides a program for the diagnosis, evaluation and effective treatment of substance abuse, including detoxification and infirmary-level medical services. The treatment must be provided by licensed nurses under the direction of a full-time registered nurse and the supervision of a staff of physicians. The facility must also prepare and maintain a written treatment plan for each patient based on the patient's medical, psychological and social needs.

Vision Examination – An examination by an ophthalmologist or an optometrist that includes, but is not limited to, history, external examination of the eye, examination to determine any refractive error, measurement of the ability to focus both eyes, examination of the interior of both eyes (by instrument), and a prescription for corrective lenses, if necessary.

An Overview of Your Medical Options

Montefiore offers two medical options from which you can choose – MonteCare EPO and MonteCare PPO. While each of the options generally covers the same healthcare services, they differ in the following areas:

- Your share of the cost – including:
  - Premiums you pay based on which option you choose, whether you elect single or family coverage, your salary level and whether or not you use tobacco

    plus
  - Deductibles, copayments or coinsurance you pay when you receive healthcare services.
- **Provider selection** – MonteCare EPO and MonteCare PPO both use the Empire BlueCard PPO and Montefiore Network:
  - MonteCare EPO requires you to use in-network providers to receive benefits. Your share of the cost will be higher when you use Empire BlueCard PPO Network Non-preferred facilities and providers outside of Montefiore and the MIPA.
  - MonteCare PPO gives you the flexibility to choose any provider you wish however, you'll pay more for healthcare services if you use Empire BlueCard PPO Network Non-preferred Facilities or Out-of-network Providers.

Provider Network

Provider networks include hospitals, laboratories, physicians and other healthcare providers who have agreed to charge negotiated rates for their services.

For	MonteCare EPO/MonteCare PPO Network
Hospitals and Other Facilities	• Empire BlueCard PPO – Preferred Facilities – Non-Preferred Facilities • Montefiore Network (including Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital, White Plains Hospital, Burke Rehabilitation Hospital, Montefiore Ambulatory Surgical Facilities, Montefiore Imaging Center, Montefiore Department of Radiology, Advanced Endoscopy Center and NY GI Center)
Skilled Nursing Facility, Hospice	Empire BlueCard PPO Network and Schaffer Extended Care Center
Laboratories	Quest Laboratories, LabCorp and any hospital laboratory participating in the Empire BlueCard PPO Network and Montefiore Network (including Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital)
Pharmacies	Express Scripts participating retail pharmacies, Home Delivery Pharmacy Service and Montefiore outpatient pharmacies
Physicians, Therapists and Counseling for Mental Health and Substance Abuse	Montefiore Integrated Provider Association (MIPA), Empire BlueCard PPO Network, Montefiore Behavioral Care Integrated Provider Association (MBCIPA) and Empire Behavioral Health Network

Empire BlueCard PPO Network

Under MonteCare EPO and MonteCare PPO, the Empire BlueCard PPO Network has two tiers of coverage for facility charges – Network Preferred Facilities and Network Non-Preferred Facilities. Your share of the cost will be higher when you use a Non-Preferred Facility for inpatient, outpatient and High-Tech Radiology Services[1].

Network Non-Preferred Facilities are non-Montefiore[2] inpatient, outpatient and free-standing diagnostic imaging facilities located in the **Bronx, Westchester and Manhattan** (*only*). These facilities include, **but are not limited to**:

- CareMount Medical (Mount Kisco Medical Group)
- Hospital for Special Surgery
- Memorial Sloan-Kettering
- Mount Sinai Health System
- New York Presbyterian System (including Lawrence Hospital, Columbia University, Weill Cornell Medical Center)
- Northwell Health (including Lenox Hill Hospital, Northern Westchester Hospital, Phelps Memorial Hospital)
- NYU Langone Medical Center
- Westchester Medical Center.

Inpatient Pre-certification at Non-Montefiore Hospitals

Inpatient care at non-Montefiore hospitals must be pre-certified through Conifer Value Based Care. If you fail to pre-certify, you will pay a higher inpatient coinsurance or copayment than is otherwise required under the MonteCare EPO and MonteCare PPO plans. Pre-certification ensures that services are medically necessary and provided in an appropriate treatment setting *before you submit* a claim.

To request pre-certification:

1. Call Conifer at 855.381.3441 to notify the Conifer Nurse about the patient and the procedure requiring a pre-determination.
2. Conifer will provide a determination within 15 business days, though typically sooner and reach out to your provider's office with the determination.
3. Conifer will send the pre-determination to Empire Blue Cross Blue Shield so the claim is processed accordingly.

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1 High-Tech Radiology Services include, but are not limited to, diagnostic MRIs, MRAs, CAT Scan, PET Scan and Nuclear Radiology.

2 This does not include Montefiore affiliates Riverside HealthCare System and St. Joseph's Medical Center.

Once a stay is pre-certified, Conifer Value Based Care will notify:

- Empire BCBS to ensure that the correct copayment is applied, and
- Care Guidance, so they can offer medical management services, including coordinating with you or a covered dependent at critical points in care, helping to answer questions related to your inpatient stay and providing information about resources for after care.

To minimize your out-of-pocket costs, it is important that you contact Conifer Value Based Care:

- 14 days before a non-emergency inpatient admission
- Within 48 hours or as soon as is reasonably possible after an emergency admission
- When newborn inpatient hospital stays exceed 48 hours for vaginal delivery and 96 hours for C-Section.

Empire BlueCard PPO Network Facility Charges

Empire BlueCard PPO Network has two tiers of coverage for facility charges – Network Preferred Facilities and Network Non-Preferred Facilities.

Your Cost If You Use:	Montefiore Network	Empire BlueCard PPO Network		Out-of-network
		Preferred Facilities	Non-preferred Facilities	
INPATIENT CARE				
MonteCare EPO	$0	20%[1] coinsurance after deductible if precertified by Conifer Value Based Care[3]; otherwise 30%[1] coinsurance after deductible	40%[1] coinsurance after deductible if precertified by Conifer Value Based Care[3]; otherwise 50%[1] coinsurance after deductible	Not covered except in the case of an emergency admission
MonteCare PPO	$0	$1,000 copay if precertified by Conifer Value Based Care[3]; otherwise $1,500 copay	$2,000 copay if precertified by Conifer Value Based Care[3]; otherwise $2,500 copay	40%[2] coinsurance after $1,000 copay if precertified by Conifer Value Based Care[3]; otherwise $1,500 copay
HIGH-TECH RADIOLOGY SERVICES				
MonteCare EPO	$0	20%[1] coinsurance after deductible	40%[1] coinsurance after deductible	Not covered
MonteCare PPO	$0	$250 copay	$500 copay	40%[2] coinsurance after deductible
OUTPATIENT SURGERY				
MonteCare EPO	$0	20%[1] coinsurance after deductible	40%[1] coinsurance after deductible	Not covered
MonteCare PPO	$0	$500 copay	$1,000 copay	40%[2] coinsurance after deductible

1 Percentage is applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e. the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

2 Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

3 Pre-certification will ensure that services are medically necessary and provided in an appropriate treatment setting.

The Deductible

The *deductible* is the amount you must pay before benefits for certain covered services are paid. The deductible applies to each covered individual once each calendar year until the family deductible is met. The covered expenses of all family members may be used to help meet the family maximum.

The amount of the deductibles depends on the option and level of coverage you elect, as follows.

	Montefiore Network	**Empire BlueCard PPO Network**	**Out-of-network**
MonteCare EPO Individual/Family Deductible	None	$500/$1,000	Not covered
MonteCare PPO Individual/Family Deductible	None	$500/$1,000	$1,000/$2,500

The deductible does not apply to services provided at Montefiore facilities and by Montefiore providers

Annual Out-Of-Pocket Maximum

The annual out-of-pocket maximum is the maximum total dollar amount you have to pay for eligible medical expenses including coinsurance, deductibles and copayments (up to R&C limits) in any calendar year.

Once your share of eligible expenses reaches the out-of-pocket maximum, the plan pays 100% of covered services for the remainder of the calendar year. If you are enrolled for family coverage and one family member reaches the individual out-of-pocket maximum amount, the plan will pay 100% of that family member's eligible expenses for the rest of the calendar year. The expenses of any remaining family member or members would then be applied to the family maximum amount. No one individual is required to pay more than the individual out-of-pocket amount.

Here are the annual out-of-pocket maximums for each medical option.

	In-network	**Out-of-network**
MonteCare EPO		
· Individual/Family Out-of-pocket Maximum (Deductible + Copayments + Coinsurance)	$5,350/$10,700	Not covered
MonteCare PPO		
· Individual/Family Out-of-pocket Maximum (Deductible + Copayments + Coinsurance)	$5,350/$10,700	$6,000/$17,500
Express Scripts – Individual/Family Out-of-Pocket Maximum		
· Prescription Drug – Copayments + Coinsurance Note: Does not include the difference between the cost of generic and brand name drugs when a generic equivalent is available	$1,500/$3,000	

Covered Expenses

In-hospital Care

The medical options cover semi-private hospital room, board and medical supplies for up to 365 days of treatment. If only private rooms are available, the medical options cover those charges up to the prevailing semi-private room rate in the area in which treatment is received.

Inpatient expenses include:

- Anesthesia supplies and use of equipment
- Dressings and plaster casts
- Drugs and medicines for use in the hospital
- General nursing care (in-hospital private duty nursing care is not covered)
- Intensive care, coronary care or other special care units and equipment
- Medical services and supplies customarily provided by the hospital, other than personal convenience items
- Oxygen and use of equipment for its administration
- Use of blood transfusion equipment and administration of blood or blood derivatives if administered by a hospital employee
- Use of operating, cystoscopic and recovery rooms
- X-rays and laboratory examinations.

Coverage is also provided for:

- Cosmetic Surgery – if needed to repair damage caused by an accident or a birth defect
- Dental work or surgery if your physician certifies that hospitalization is necessary to safeguard your life
- Maternity care – a minimum of 48 hours following vaginal delivery; 96 hours following delivery by cesarean section; earlier release is possible after consultation between the attending physician and the mother
- Organ and tissue transplants – if the covered person is the recipient (benefits for the donor will also be covered if that person is not covered by any other group health insurance plan)
- Prosthetics and orthotics – when billed with another covered service such as minor/ambulatory surgery, cataract surgery or breast reconstructive mandates
- Treatment in a hospital emergency room or similar facility for a bona fide medical emergency

- Well baby nursery and physicians' charges during the initial confinement while the mother is confined in the same hospital – for up to the number of days medically necessary and appropriate for the type of delivery (well-baby nursery care will not be paid for any additional days the mother remains hospitalized due to an illness, injury or complications following delivery).

Inpatient Psychiatric Care/Substance Abuse

The medical options provide benefits for inpatient psychiatric care and substance abuse – in either a general hospital or special treatment facility.

For purposes of this benefit, a general hospital means the following:

- In New York State
  - For alcoholism – a facility certified by the New York State Division of Alcoholism and Alcohol Abuse
  - For substance abuse – a facility certified by the New York State Division of Substance Abuse Services
- Outside of New York State – a facility with a treatment program approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Alternatives to In-hospital Care

MonteCare provides benefits for services and supplies provided by the following alternatives to in-hospital care:

- ***Home Healthcare*** – up to a maximum of 200 visits in a calendar year. Each visit by a member of a home healthcare team counts as one home healthcare visit. Up to four hours of home health aide services count as one home healthcare visit. Home healthcare benefits are limited to 12 hours of care a day.

  Covered services must be provided by a certified home health agency and include:

  - Ambulance or ambulette to the hospital for needed care
  - Home infusion therapy
  - Medical social worker visits
  - Medical supplies, drugs and medicines prescribed by a physician
  - Necessary laboratory services
  - Part-time home health aide services
  - Part-time professional nursing
  - Physical, occupational or speech therapy.
  - X-ray and EKG services.
- **Ambulatory Surgical Facility**
- **Birthing Center**
- ***Hospice*** – for the medical care and treatment of a terminally ill patient for up to 210 days – provided the care is not primarily custodial. The care must be recommended by a physician and provided at any licensed facility or at home.
- **Skilled Nursing Facility** – up to 120 days each calendar year.

BENEFIT SUMMARY

	MonteCare EPO Your Cost If You Use:			MonteCare PPO Your Cost If You Use:		
	Montefiore Network	**Empire BlueCard PPO Network**	**Out-of-network**	**Montefiore Network**	**Empire BlueCard PPO Network**	**Out-of-network**
Emergency Room Care						
• Bona fide emergency – copayment waived if admitted	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay
• Other than a bona fide emergency	20%[1] coinsurance	20%[1] coinsurance after deductible	Not covered	30%[1] coinsurance after deductible	30%[1] coinsurance after deductible	30%[2] coinsurance after deductible
• Urgent Care Facility	$0	$30 copay	Not covered	$0	$30 copay	30%[2] coinsurance after deductible
• Urgent Care Professional	$15 copay	$30 copay	Not covered	$15 copay	$30 copay	30%[2] coinsurance after deductible
Ambulatory Surgical Facilities	$0	20%[1] coinsurance after deductible	Not covered	$0	$500 copay	30%[2] coinsurance after deductible
Birthing Center	$0	20%[1] coinsurance after deductible	Not covered	$0	$500 copay	30%[2] coinsurance after deductible
Home Infusion Therapy – (not in conjunction with Home Healthcare)	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Home Healthcare – up to 200 visits in a calendar year	$0	$0	Not covered	$0	$0	30%[2] coinsurance after deductible
Hospice – up to 210 days	$0	$0	Not covered	$0	$0	30%[2] coinsurance after deductible
Skilled Nursing Facility – up to 120 days	$0	$0	Not covered	$0	$0	30%[2] coinsurance after deductible

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

[2] Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

Outpatient Medical/Surgical Services

The medical options pay the following in-network and out-of-network benefits for services and supplies, if prescribed by a physician and medically necessary for the treatment or diagnosis of a covered condition.

Covered outpatient medical/surgical services and supplies include:	MonteCare EPO Your Cost If You Use: [3]			MonteCare PPO Your Cost If You Use: [3]		
	Montefiore Network	Empire BlueCard PPO Network	Out-of-network	Montefiore Network	Empire BlueCard PPO Network	Out-of-network
· Preventive Care · Gynecological Exams (routine) · Immunizations – Hepatitis A, Annual Flu Shot, Tetanus, Pneumococcal · Nutrition Counseling – limited to 6 visits in a calendar year, if referred by a physician. In-network providers are Registered Dietitians in the Empire BlueCard PPO Network, including Montefiore Registered Dietitians · Physical Exams (routine) – once in a calendar year · Well Child Care – limited to 11 visits up to age 2. · Well Woman Care – Screening for gestational diabetes – HPV testing – Contraceptive methods and counseling – Breast feeding support, supplies and counseling – Counseling for sexually transmitted infections – Counseling and screening for HIV – Screening and counseling for interpersonal and domestic violence	$0	$0	Not covered	$0	$0	30%[2] coinsurance after deductible

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

[2] Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

Covered outpatient medical/surgical services and supplies include:	MonteCare EPO Your Cost If You Use: [3]			MonteCare PPO Your Cost If You Use: [3]		
	Montefiore Network	Empire BlueCard PPO Network	Out-of-network	Montefiore Network	Empire BlueCard PPO Network	Out-of-network
Acupuncture – for the treatment of nausea and vomiting related to chemotherapy and pregnancy, osteoarthritis of the knee, post-operative dental pain, and post-operative nausea and vomiting in adults – limited to 12 treatments in a 12-month period	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Advanced Reproductive Technologies – up to a maximum combined in-network and out-of-network lifetime benefit of $12,000; for treatment (hospital, surgical, medical) including: · artificial insemination · in-vitro fertilization/ZIFT/GIFT/ICSI	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Alcohol/Substance Abuse Treatment	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Allergy Care – testing and treatment	$15 copay/day; $0 for treatment	20%[1] coinsurance after deductible	Not covered	$15 copay/day; $0 for treatment	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Ambulance Service – in a medical emergency to the nearest medical facility equipped to treat that condition or if medically necessary	20% coinsurance	20%[1] coinsurance	20%[2] coinsurance	20% coinsurance	20%[1] coinsurance	20%[2] coinsurance
Anesthesia Services – if performed by a licensed anesthesiologist in connection with a surgical procedure.	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[1] coinsurance after deductible
Birth Control – IUDs, diaphragm fittings, Norplant	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1]coinsurance after deductible	30%[2] coinsurance after deductible
Blood, Blood Plasma or Blood Derivatives	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Cardiac Rehabilitation	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Chemotherapy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Chiropractic Services – 10 visits	$50 copay/visit	20%[1] coinsurance after deductible	Not covered	$35 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Circumcision – if performed before the newborn leaves the hospital	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Consultations and Surgical Opinions	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

[2] Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

Covered outpatient medical/surgical services and supplies include:	MonteCare EPO Your Cost If You Use: [3]			MonteCare PPO Your Cost If You Use: [3]		
	Montefiore Network	Empire BlueCard PPO Network	Out-of-network	Montefiore Network	Empire BlueCard PPO Network	Out-of-network
Dental Services: · extractions of impacted wisdom teeth and other teeth impacted in bone which require oral surgery · treatment of an injury to sound natural teeth within 12 months of the date of injury	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Durable Medical Equipment – purchase and rentals	Professional provider: 20%[1] coinsurance; Facility: $0	Professional provider: 20%[1] coinsurance; Facility: 20%[1] coinsurance after deductible	Not covered	Professional provider: 20%[1] coinsurance; Facility: $0	Professional provider: 20%[1] coinsurance; Facility: 20%[1] coinsurance after deductible	Professional provider: 20%[2] coinsurance; Facility: 20%[2] coinsurance after deductible
Foot Care – routine care for up to 8 visits/calendar year	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Genetic Testing (physician must certify that it is medically necessary)	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Hearing Aids (including batteries and repairs; each ear, once every 3 calendar years)	20% coinsurance	20%[1] coinsurance after deductible	Not covered	20%[1] coinsurance	20%[1] coinsurance after deductible	20%[2] coinsurance after deductible
Hearing Exam (1 per calendar year)	20% coinsurance	20%[1] coinsurance after deductible	Not covered	20%[1] coinsurance	20%[1] coinsurance after deductible	20%[2] coinsurance after deductible
Hemodialysis	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Laboratory Tests – including routine pap smear	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Medical Supplies	$0	20%[1] coinsurance after deductible	Not covered	$0	20%[1] coinsurance after deductible	20%[2] coinsurance after deductible (covered at in-network level)
Mental Healthcare	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Obstetrical (Maternity) Care – including termination of pregnancy, certified nurse-midwife	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Orthotics	20% coinsurance	20%[1] coinsurance	Not covered	20% coinsurance	20%[1] coinsurance	20%[2] coinsurance
Outpatient Diagnostic and Laboratory Tests - X-rays, bone density, diagnostic mammography, blood, urine, etc.	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Physical, Occupational and Speech Therapy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

[2] Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

Covered outpatient medical/surgical services and supplies include:	MonteCare EPO Your Cost If You Use: [3]			MonteCare PPO Your Cost If You Use: [3]		
	Montefiore Network	Empire BlueCard PPO Network	Out-of-network	Montefiore Network	Empire BlueCard PPO Network	Out-of-network
Physicians' Visits						
· In-hospital by your attending physician	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
· Office visits including emergency care/first aid and medical evaluations	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
· Specialist office visits	$15 copay/visit	20%[1] coinsurance after deductible	Not covered	$15 copay/visit	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Polysomnograms	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Pre-surgical/Pre-admission tests – if performed within 14 days of a scheduled hospital admission	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Prosthetics – including lenses and/or glasses after cataract surgery, wigs and toupees	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Radiation Therapy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Radiologist's Fees	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Reconstructive Surgery Following a Mastectomy – while the person is covered by MonteCare – including: · reconstruction of the breast on which the mastectomy was performed · surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses · treatment of physical complications at all stages of the mastectomy, including lymphedemas	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Respiratory Therapy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Shock Therapy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Sleep Disorders – treatment of sleep apnea and narcolepsy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Sterilization (but not reversals)	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Surgeons' and Assistant Surgeons' Fees	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible
Vision Therapy	$0	20%[1] coinsurance after deductible	Not covered	$0	10%[1] coinsurance after deductible	30%[2] coinsurance after deductible

[1] If you use a non-participating provider or facility, percentages are applied to covered charges which are based on the rate paid to like-kind Empire in-network facilities if the facility is within the Empire area (i.e., the New York metropolitan area including NJ and CT) or the facility's actual charge if it is outside of the Empire area.

[2] Reasonable and Customary charges are based on 150% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

Transgender-inclusive Healthcare Coverage

For the purposes of determining eligibility for coverage and subsequent payment of claims under the sex reassignment surgical benefit, services will be regarded as medically necessary for the individual and covered when providers document that the diagnostic, assessment and treatment process is consistent with generally recognized standards of medical practice. Specifically, diagnosis and treatment conforming to the current WPATH SOC, as appropriately documented by the treating provider(s), will be regarded as sufficient: additional restrictions will not be placed nor other documentation required to determine eligibility or authorization.

Maximum Benefits

Montefiore medical benefits generally provide *unlimited* in-network and out-of-network maximum lifetime benefits for you and each covered family member.

However, some covered services are subject to separate limits and/or annual maximum benefits. These limits and maximums apply to each covered individual and are:

- Acupuncture – limited to 12 treatments in a 12-month period
- Chiropractic services – up to 10 visits each calendar year
- Foot care – routine care for up to eight visits in a calendar year
- Hearing Aids (including repairs and batteries; each ear, once every three years)
- Hearing Exam (one per calendar year)
- Home healthcare – up to 200 visits each calendar year
- Hospice care – for up to 210 days
- In-vitro fertilization/ZIFT/GIFT/ICSI – $12,000 for all medical services, $12,000 for prescription drugs
- Morbid Obesity – surgical treatment (limited to one procedure in a lifetime)
- Nutrition counseling – six visits in a calendar year
- Physical exams (routine) – once in a calendar year
- Travel and lodging expenses for a patient and one companion
  - up to a maximum benefit of $10,000
  - limited to $125/day for meals and lodging for transplants
- Skilled nursing facility – limited to 120 days each calendar year
- Well child care – limited to 11 visits up to age 2.

Exclusions

The medical options do *not* pay benefits for all medical services and supplies – even if recommended by a physician. Expenses *not* covered include:

- Acupuncture – for anesthetic purposes in conjunction with surgery
- Complications arising from non-covered surgery
- Conditions, disabilities or expenses caused by:
  - commission of or participation in a crime
  - riot or war (declared or not)
  - serving in the armed forces
  - an illegal occupation
  - an occupational illness or injury
- Cosmetic surgery, except as specified under covered services
- Counseling – marital, family or sex counseling (unless provided by the EAP staff counseling service)
- Custodial, sanitarium or rest care
- Dental services for
  - X-ray examinations in conjunction with mouth conditions due to periodontal or periapical disease
  - any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue
  - treatment of temporomandibular joint dysfunction (TMJ) when dental in nature
  - inpatient dental treatment unless certified by your physician to safeguard your life
- Donor search/Compatibility fee
- Drugs or medicines – prescription and non-prescription unless provided by a Hospital or dispensed from a doctor's office
- Eating disorders, except bulimia and anorexia nervosa
- Equipment that can be used by someone who is not ill or injured, such as air conditioners, air purifiers, heating pads, water beds, swimming pools, etc.

- Expenses:
  - for broken appointments, telephone consultations, filling out medical reports, medical bills, and benefit request forms
  - for care to correct learning or behavioral disorders
  - for education, vocational counseling, and job training
  - **in excess of reasonable and customary limits**
  - incurred before coverage starts or after it ends
  - related to the insertion or maintenance of an artificial heart
  - to the extent, they are reimbursable under another employer's plan or any other source of payment
- Eyeglasses and contact lenses except after Cataract Surgery
- Foot care
  - Symptomatic complaints of the feet except capsular or bone surgery related to bunions and hammertoes
  - Orthotics for treatment of routine foot care
- Hearing aid insurance
- High Dose Chemotherapy with Autologous Bone Marrow Transplant ("HDCT-ABMT")
- Hospital confinement primarily for diagnostic studies
- Hypnosis (except for anesthetic purposes)
- Intentionally self-inflicted illness or injury
- Lamaze class
- Laser eye surgery
- Massage therapy and Rolfing
- Medically necessary services that can be provided without the assistance of trained medical personnel – e.g., injections for diabetes, riding a bike as part of physical therapy, etc.
- Minoxidil (Rogaine)
- Penile prosthetic implant
- Personal comfort or service items while you are in the hospital, such as phones, radio, television, guest meals, etc.
- Private duty nursing

- Professional services provided by you, a family member or by someone who lives in your home
- Radial keratotomy and related procedures
- Services and/or supplies:
  - covered under the mandatory portion of a no-fault automobile insurance policy, if no-fault benefits are recovered or recoverable
  - for medical procedures or treatments
    - considered experimental, investigational or educational
    - provided primarily for research
    - not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness, injury or pregnancy
  - for recreational therapy
  - for smoking cessation programs including transdermal patches or Nicorette gum
  - for which there is no legal obligation to pay or charges that would not have been made except for the availability of benefits from MonteCare EPO or MonteCare PPO
  - not ordered by a physician
  - provided by a Health Maintenance Organization (HMO)
  - provided by the government, unless you are legally required to pay for the care you receive
  - **which are not specifically listed as covered expenses in this Summary Plan Description**
  - which result from illness or injuries caused by a third party unless a subrogation agreement has been executed by you and/or the appropriate family member
- Sleeping disorders – treatment of sleeping disorders, including bruxism (grinding of teeth), drug dependency, dream anxiety attacks, shift work or schedule disturbances and migraine headaches (except as specified under covered services)
- Specialty Medications (However, they are covered under prescription drug benefits through Montefiore's outpatient pharmacies, Express Scripts participating retail pharmacies or Accredo.)
- Sterilization – procedures to reverse voluntary sterilization
- Surrogate expenses
- Vaccinations, inoculations or immunizations, except as specified under covered services
- Vision perception training

- Vitamins, minerals and food supplements
- Weight reduction – treatment, instructions, activities or drugs for weight reduction or control, except for the diagnosed condition of morbid obesity.

Non-Duplication of Benefits

The medical options contain a non-duplication of benefits feature. This feature applies when you or a family member is covered by more than one group medical plan. It limits payments from all sources combined to no more than the medical options would pay if there had been no other coverage. The provision also applies to Medicare, Champus/Tricare and any other government programs with which the medical options are allowed to coordinate by law. The non-duplication of benefits provision does not apply to any personal policy, except no-fault automobile insurance. This provision does not apply to Medicaid or any other government programs with which the medical options are not allowed to coordinate by law.

Under the non-duplication of benefits provision, the plan that has primary responsibility always pays first. Briefly, non-duplication of benefits works like this.

- When the other plan does not have a non-duplication or coordination of benefits provision, it is considered primary.
- When both plans have a non-duplication or coordination of benefits provision:
  - The plan covering the person as an employee is primary and will pay benefits up to the limits of that plan; the plan covering the person as a dependent, retiree or COBRA participant (terminated employee who elected COBRA coverage) is secondary and pays any remaining eligible costs.
  - The plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay children's benefits first; the plan covering the other parent pays second and pays the remaining costs to the extent of coverage. This is called the "birthday" rule and is currently used by the medical options.
  - In those plans which do not include the "birthday" rule, the father's plan is primary and will pay children's benefits first; the mother's plan pays second. This is called the "male-female" rule.
  - If one parent is covered by the "male-female" rule and the other by the "birthday" rule, the "male-female" rule applies.
  - If the parents of a dependent child are divorced or legally separated, the claims administrator will determine if there is a court decree which establishes financial responsibility for medical and dental care. If there is such a decree, the plan covering the parent who has that responsibility will be primary and pays first.

- If there is no decree, the plan which covers the child as a dependent of the parent with custody is primary and pays first; the other parent's plan is secondary.
- If there is no decree and the parent with custody remarries, that parent's plan remains primary; the stepparent's plan is secondary; the non-custodial parent's plan is third.

- If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan and pays first.

Under non-duplication of benefits, if your medical option pays benefits second, it will not duplicate any benefits that have already been paid. If the other plan pays as much or more than your medical option, no payments will be made.

For example, suppose your spouse's medical plan covered a hospital bill at 80%, and your medical option would have covered that same bill at 80%. Since your spouse already received benefits from his or her plan equal to what your medical option would have paid, no benefits would be paid.

The non-duplication of benefits feature also applies to the Express Scripts Prescription Drug Program. If the Express Scripts Prescription Drug Program is the secondary payer, you can submit a claim to Express Scripts after you have been reimbursed from the primary plan. A copy of the primary plan's Explanation of Benefits (EOB) must accompany the claim form.

Claims should always be submitted to the primary plan first.

Coordination with an HMO

The medical options also coordinate benefits with an HMO if:

- You are covered as a dependent under your spouse's (or qualified domestic partner's) HMO and are also enrolled in a Medical option

  or

- Your spouse (or qualified domestic partner) is covered by an HMO and is also enrolled as your dependent in a Medical option.

In these instances, you may file a claim under Montefiore medical benefits for expenses not covered by the HMO. If the claim is for a covered expense, the option will pay its regular benefit.

Coordination with Medicare

Montefiore medical benefits provide primary coverage for the following covered Medicare-eligible individuals:

- Active associates and their spouses age 65 or older
- Individuals with End Stage Renal Disease for 30 months or less
- Covered disabled dependents of active associates.

If you are an active associate age 65 or over and eligible for Medicare, you can elect primary coverage under Medicare. However, if you do, no benefits will be payable under Montefiore medical benefits.

In addition, if you continue to work after age 65, you should notify the Social Security Administration. Otherwise, when you eventually enroll for Medicare, you will pay a higher premium.

Non-Assignment of Benefits

Except as may be required by the Internal Revenue Code or ERISA, you may not assign, pledge, borrow against or otherwise promise any benefit payable under the Plan before receipt of that benefit. You also may not assign or pledge any right you may have to file a lawsuit against the Montefiore Medical Center Employee Health & Welfare Plan, Montefiore Medical Center, any participating employers, or officers or employees thereof, the Plan Administrator or any Plan fiduciary. However, you may request, in writing and at the discretion of the Plan Administrator or its delegate, that a reimbursement for benefits payable to you be paid instead to the person rendering the service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and Montefiore Medical Center to the extent of such payment.

If You Continue to Work after Age 65

You may be eligible for Medicare if you:

- are age 65 and older, or
- have received Social Security disability benefits for 24 months, have ALS (Amyotrophic Lateral Sclerosis) or have permanent kidney failure.

If you enroll in Medicare and continue to work, you and your family members are still eligible to be covered by Montefiore medical benefits.

If You Enroll in Medicare

If you choose to be covered by Medicare and Montefiore medical benefits, your Montefiore coverage will be primary to Medicare. Medicare will become your secondary plan and provide coverage for eligible expenses that your Montefiore coverage does not cover or if the plan pays less than Medicare would pay if Medicare had been primary.

If you are disabled as a result of End Stage Renal Disease ("ESRD") your Montefiore coverage will only be primary for a 30-month period beginning the first of the month in which you become eligible or enrolled in Medicare Part A.

If you waive Montefiore coverage, Medicare will be your primary insurance plan. You will not be eligible to receive medical benefits from Montefiore because federal law prohibits offering supplemental benefits for expenses covered under Medicare to active employees or their dependents.

If You Do Not Enroll in Medicare

If do not enroll in Medicare Part B when you first become eligible, you may be eligible to enroll (without a late penalty) during a Special Enrollment Period (SEP), if you are continuously covered by Montefiore until:

- you elect to waive coverage, or
- you are no longer eligible for coverage.

The Special Enrollment Period is open for eight months after Montefiore's coverage ends. For more information go to **www.medicare.gov**

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are available through Montefiore outpatient pharmacies and Express Scripts participating retail pharmacies and home delivery pharmacy service.

What the Prescription Drug Section Includes

Prescription Drug Benefits

Prescription drug benefits are available for associates who elect medical coverage.

- If you elect the MonteCare EPO or MonteCare PPO, Montefiore's outpatient pharmacies provide prescription drug benefits for you and your covered family members up to a:
  - 30-day supply for new prescriptions for chronic medications and seasonal allergy medications.
  - 90-day supply for refills and all other medications.
- Generic medications will be filled at no cost to you through Montefiore outpatient pharmacies. If you obtain a preferred formulary brand name drug:
  - when a generic equivalent is not available, you are responsible for the $20 copayment for a 30-day supply; $40 for a 90-day supply.
  - when a generic equivalent is available, you will pay the difference in cost between the generic and preferred formulary brand name drug.
- Express Scripts prescription drug benefits are also available through:
  - Participating retail pharmacies (up to a 30-day supply of each prescription).

    If you use a non-participating pharmacy in an area where there is a participating pharmacy available, your reimbursement will be 75% of the R&C cost of the prescription.
  - Home Delivery Pharmacy Service
    - 30-day supply for new prescriptions for chronic medications and seasonal allergy medications.
    - 90-day supply for refills and all other medications.
  - If you purchase a preferred formulary brand name medication when a generic equivalent is available, you are responsible for the retail or mail order generic copayment plus the difference in cost between the generic and the preferred formulary brand name medication. The difference in cost between generic and the brand name medications is not included in the out-of-pocket maximum and is not eligible for 100% reimbursement after the out-of-pocket maximum has been met.

Copayments for preferred formulary brand name drugs obtained through Montefiore outpatient pharmacies are significantly lower than the copayments you pay at Express Scripts participating retail pharmacies or through the Home Delivery Pharmacy Service.

Prescription Drug Out-of-pocket Maximum

Your share of expenses for prescriptions obtained from Montefiore outpatient pharmacies, Express Scripts participating retail pharmacies, home delivery pharmacy service or out-of-network pharmacies is limited to $1,500 for any one covered person ($3,000 for a family) in a calendar year. Once that maximum is reached, the Plan pays 100% of any remaining prescription drug expenses for that individual for the rest of the calendar year. The expenses of any remaining family member or members would then be applied to the family maximum amount. No one individual is required to pay more than the individual out-of-pocket amount.

Covered Expenses

Copayments are based on the generic, preferred, non-preferred or specialty drug classification of each prescription.

	Your Cost If You Purchase:			
	Generic	**Preferred (Formulary)**	**Non-Preferred (Non-Formulary)**	**Specialty**
Montefiore Outpatient Pharmacies[1]				
– 30-day supply for new prescriptions for chronic medications and seasonal allergy medications	$0	$20 copay	You pay 100% of discounted cost	$20 copay
– 90-day supply for refills and all other medications	$0	$40 copay	You pay 100% of discounted cost	$40 copay
Express Scripts [1]				
• Retail pharmacy[2] (up to a 30-day supply of each prescription)	$15 copay	$45 copay	You pay 100% of discounted cost	$100 copay
• Home Delivery Pharmacy Service				
– 30-day supply for new prescriptions for chronic medications and seasonal allergy medications	$15 copay	$45 copay	You pay 100% of discounted cost	$100 copay
– 90-day supply for refills and all other medications	$30 copay	$90 copay	You pay 100% of discounted cost	$150 copay

1. If you purchase a preferred formulary brand name medication when a generic equivalent is available, you are responsible for the generic copayment plus the difference in cost between the generic and preferred formulary brand name medication.
2. If you use a non-participating pharmacy in an area where there is a participating pharmacy available, your reimbursement will be 75% of the R&C cost of the prescription.

Specialty Medications

Specialty medications are not covered under MonteCare EPO or MonteCare PPO. However, they are covered under Montefiore's prescription drug benefits after prior authorization and when filled through Montefiore's outpatient pharmacies, Express Scripts participating retail pharmacies or Express Scripts' specialty pharmacy, Accredo.

Note: If a specialty medication is not available at a Montefiore outpatient pharmacy, you may fill the prescription through Express Scripts' specialty pharmacy, Accredo, and pay the Montefiore outpatient pharmacy copayment. If a specialty drug needs to be mailed out of state, you must use Express Scripts' specialty pharmacy, Accredo. The Montefiore outpatient pharmacy copayment will also apply in this situation.

Utilization Management Features

The following plan features are designed to increase the quality and safety of the Prescription Drug Program. In addition, they can help keep prescription drug costs under control – for you and Montefiore.

- ***Drug Utilization Review*** – is designed to ensure that plan participants receive appropriate prescription medication. Express Scripts reviews your prescriptions and will contact your doctor if they identify potentially unsafe prescribing patterns. Express Scripts' determination is based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

  The review also regulates the timing between prescription refills. You must use at least 75% of a prescription before a refill will be approved. If you need a prescription refill sooner – for example, if you will be traveling – you can call Express Scripts for a waiver.

- ***Preferred Drug Step Therapy (PDST)*** – Before using a higher cost non-preferred drug, you are required to try a generic alternative or preferred brand name medication first. If your doctor prescribes a non-preferred drug, Express Scripts will work with your doctor to see if a generic alternative or preferred brand name medication would be equally effective. (In some cases, special circumstances may require you to use a non-preferred drug.)
  Note: If your prescription history shows that you have already tried preferred drugs, your prescription will be filled without a review.

- ***Drug Specific Prior Authorization*** – This feature insures that drugs are being used for their designed purpose. Express Scripts will review your prescriptions and contact your doctor to determine if your prescription qualifies for drug coverage based on nationally accepted clinical guidelines and standards. If you are taking drugs that require prior authorization, Express Scripts will notify you and provide you with instructions for beginning a coverage review.
- ***Quantity/Dose Limitations*** – Prescriptions for generic and brand name medications will only be filled in quantities and doses that are consistent with manufacturer and FDA clinical guidelines. If your doctor prescribes a drug in a quantity/dose that exceeds these guidelines your prescription will be filled according to the guidelines. If you are currently taking a drug in a quantity that is affected by these guidelines you will be pre-notified by Express Scripts – at which point you or your physician can initiate a coverage review process in order for greater quantities to be filled.

Medicare Part D Notice

IMPORTANT NOTICE FROM MONTEFIORE 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 Montefiore and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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. **Montefiore has determined that the prescription drug coverage offered by Montefiore's medical options is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, you will still be eligible to receive all of your current health and prescription drug benefits, provided you continue your Montefiore coverage.

If you do decide to join a Medicare drug plan and drop your current Montefiore coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Montefiore and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or Montefiore Prescription Drug Coverage

Call Montefiore's HR-Benefits Office at **914.349.8531**.

NOTE: You will receive this notice each year before the next period you can join a Medicare drug plan, and if Montefiore's coverage changes. You also may request a copy at any time.

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 drug plans.

For More Information about Your Options under Medicare Prescription Drug Coverage

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of the "Medicare & You" Handbook for their telephone number) for personalized help.
- Call 800-MEDICARE **(800.633.4227)**. TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call **800.772.1213 (TTY 800.325.0778)**.

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2017
Name of Entity/Sender:	Montefiore Medical Center
Contact – Position/Office:	HR-Benefits Office
Address:	111 East 210th Street Bronx, NY 10467-2490
Phone Number:	**914.349.8531**

UNITEDHEALTHCARE VISION PLAN

Vision care benefits provide coverage for a broad range of vision services and supplies. ***Only the services and supplies specifically listed as covered in this SPD are eligible for reimbursement.***

What the UnitedHealthcare Vision Plan Section Includes

Glossary of Key Terms

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal legislation that provides participants who lose healthcare coverage with an opportunity to elect to continue healthcare coverage for a specified period of time by paying the full premium plus a 2% administrative charge.

Copayment – A flat-dollar amount you pay to a network provider for certain vision services.

Experimental/Investigational/Unproven – A healthcare service, supply, treatment or procedure that meets one or more of the following conditions for the proposed use:

- It has not been approved by the U.S. Food and Drug Administration (FDA) or identified in as appropriate
- It is under review by any institutional review board or the subject of an ongoing clinical trial
- It has not been demonstrated through prevailing peer-reviewed professional literature to be safe and effective for diagnosing or treating the condition or illness.

Necessary Contact Lenses – Contact lenses are necessary if the provider determines that an individual has:

- Keratoconus or irregular astigmatism
- Anisometropia of 3.50 diopeters or more
- Post-cataract surgery without intraocular lens

  or

- Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

Network Provider – An optometrist, ophthalmologist, optician or other licensed eye care professional who has contracted with UnitedHealthcare to provide vision care services to participants.

Ophthalmologist – A physician who specializes in eye care.

Optician – A person legally qualified to supply eyeglasses according to prescriptions written by an ophthalmologist or an optometrist.

Optometrist – A doctor of optometry who is trained and legally qualified to perform eye examinations and prescribe lenses.

Out-of-network Provider – A vision care provider who is not part of the UnitedHealthcare network.

Routine Vision Examination – An examination of the condition of the eyes and primary vision function that includes but is not limited to:

- A case history
- Testing and recording of visual acuity
- Testing how well eyes track, how they work and move together, depth perception and near point refraction
- External and internal exam
- Retinoscopy (if needed) – to determine lens power of corrective lenses
- Testing of eye pressure
- Diagnosis/prognosis and specific recommendations.

United HealthCare Insurance Company – The Claims Administrator for the UnitedHealthcare Vision Plan.

An Overview of the UnitedHealthcare Vision Plan

The UnitedHealthcare Vision Plan is an insured preferred provider vision plan. You can receive care from a network eye care professional or an out-of-network provider. Benefits are generally higher when you use a network provider. The nationwide network includes over 28,000 private practice and retail chain providers, offering convenient access to care, same-day service as well as evening and weekend hours. For a listing of participating network providers, use the online **Provider Locator** or call **800.638.3120**.

Covered Expenses

You have two UnitedHealthcare Vision Plan options from which to choose – the Low Option or the High Option. The key differences between the two options are the frequency with which you can replace frames, the copayment that applies to lenses and frames, the allowance for contact lens coverage and covered lens options. In- and out-of network benefits for each option are shown below.

	Low Option		High Option	
Benefit Frequencies				
· Exam	12 months		12 months	
· Lenses	12 months		12 months	
· Frames	24 months		12 months	
· Contacts (in lieu of eyeglasses)	12 months		12 months	
	Plan Pays		**Plan Pays**	
Service	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Comprehensive Routine Eye Exam	100% after $10 copay	Up to $50	100% after $10 copay	Up to $50
Lenses				
· Single vision	100% after $25 copay[1]	Up to $40	100% after $10 copay[1]	Up to $50
· Bifocal		Up to $60		Up to $60
· Trifocal		Up to $80		Up to $80
· Lenticular		Up to $80		Up to $80
Frames				
· Covered frames[2]	100% after $25 copay[1]	Up to $45 (any frames)	100% after $10 copay[1]	Up to $45 (any frames)
· Non-covered frames – Retail chain or private provider	Up to $130		Up to $130	
Lens Options				
· Polycarbonate lenses	100%	Not Covered (N/C)	100%	Not Covered (N/C)
· Scratch-resistant coating	100%	N/C	100%	N/C
· Ultraviolet coating	20 – 40% discount	N/C	100%	N/C
· Tinted lenses	20 – 40% discount	N/C	100%	N/C
· Basic progressive lenses	20 – 40% discount	N/C	100%	NC
· Anti-reflective coating	20 – 40% discount	N/C	100%	N/C
· Transition lenses	20 – 40% discount	N/C	20 – 40% discount	N/C
Contact Lenses (in lieu of eyeglasses) – includes fitting/evaluation, contacts and two follow-up visits				
· Covered contacts[2]	100% after $25 copay; includes up to 4 boxes of disposable lenses	Up to $125 (any contacts); $210 if medically necessary	100% after $10 copay; includes up to 6 boxes of disposable lenses	Up to $150 (any contacts) $210 if medically necessary

[1] Only one copay applies when you purchase eyeglass lenses and frames at the same time.

[2] A selection of available frames and contact lenses that are covered in full when obtained from a network provider, subject to the applicable copay.

Note: While the plan covers only one pair of glasses or contacts in any given calendar year under the benefit schedule, if you want both glasses and contacts, you can use the UnitedHealthcare Vision discount program for one ***or*** the other. A second pair discount program is in place with most retailers if the second pair is purchased at the same time.

Vision Care Discount Programs

In addition to coverage for eye exams, eyeglasses and contact lenses, the UnitedHealthcare Vision Plan includes discounts on these vision care services:

- ***Laser Eye Surgery*** – Receive 15% off the standard or usual and customary price or 5% off any promotional price of laser eye surgery procedures from the Laser Vision Network of America (LVNA). The LVNA certifies its laser vision providers according to NCQA-recommended standards. Visit the **LVNA** online or call **888.563.4497** for more information.
- ***Mail Order Contact Lens Replacement*** – Receive a 10% discount on mail order contact lens replacement through **www.uhccontacts.com** or call **855.287.0348**.

Emergency Care

Vision care to treat a medical condition due to illness or injury is not covered under the UnitedHealthcare Vision Plan. These services may be covered under your medical plan.

Using a Network Provider

To use a UnitedHealthcare network provider, follow these steps:

- Use the Provider Locator to find a network provider – online at **www.myuhcvision.com** or call **800.638.3120**.
- When you make your appointment, identify yourself as a UnitedHealthcare Vision member.
- When you visit a provider, you pay the applicable copay. The provider will bill UnitedHealthcare for the balance. You do not have to submit any claim forms.

Using an Out-of-network Provider

If your provider is not part of the UnitedHealthcare network, you pay the full cost for vision care services at the time you receive them. You must submit a claim for reimbursement within 12 months of the date of service. Your claim must include the following:

- an itemized receipt
- your Employee ID number
- the patient's name, birth date, (phone number and address if they are different from yours).

Exclusions

The following services and supplies are not covered under the UnitedHealthcare Vision Plan:

- Charges for missed appointments
- Eye examinations required by an employer as a condition of employment by a labor agreement, government organization or agency
- Medical or surgical treatment for eye disease which requires treatment by a physician
- Non-prescription items (e.g., Plano lenses)
- Optional lens extras not listed under Covered Expenses (however, discounts may be available for these options)
- Procedures that are considered experimental, investigational or unproven
- Replacement or repair of lenses and/or frames that have been lost or broken
- Sales tax charged on covered services
- Services and/or supplies:
  - Covered under Workers' Compensation or a similar employer liability law
  - Provided by the government, unless you are legally required to pay for the care you receive
  - Which are not *specifically* listed as covered expenses in this Summary Plan Description.

DENTAL BENEFITS

Dental benefits are designed to promote good dental health by providing coverage for a broad range of dental services and supplies. ***Only the services and supplies specifically listed as covered in this SPD are eligible for reimbursement.***

What the Dental Section Includes

Glossary of Key Terms

Active Course of Orthodontic Treatment – A period of treatment that begins when the first orthodontic appliance is installed and ends when the last one is removed.

Cigna – The Claims Administrator for the Preventive & Diagnostic Dental Care Option, the Cigna Dental PPO (DPPO) Option, the Cigna Enhanced DPPO Option and the Cigna Dental Health Maintenance Organization (DHMO). Cigna is not the Claims Administrator for Prescription Drug and Vision benefits, Flexible Spending Accounts or Life Insurance.

Cigna Network – A national network of dentists and specialists who have agreed to charge negotiated rates for their services, which are typically lower than they would otherwise charge.

Coinsurance – The percentage of the cost you pay for covered expenses under dental benefits once the appropriate deductibles have been satisfied.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Federal legislation that provides participants who lose healthcare coverage with an opportunity to elect to continue healthcare coverage for a specified period of time by paying the full premium plus a 2% administrative charge.

Coordination of Benefits – A provision that applies when you or a family member is entitled to benefits from this Plan and another group plan providing dental benefits. Under this provision, the benefits payable from all coverages combined are limited to 100% of the eligible expense.

Deductible – The dollar amounts that you must pay each year for certain covered services before the Cigna DPPO and Enhanced DPPO Options start paying part of the costs. There are no deductibles under the Preventive & Diagnostic Dental Care Option or the Cigna DHMO Option.

Dental Health Maintenance Organization (DHMO) – The DHMO is a group of healthcare professionals and facilities that provide dental care across a wide range of dental services.

Dentist – An individual holding a degree of Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DDM) who practices within the scope of his or her license under the laws of the state or jurisdiction in which services are provided.

Subrogation – The right of the Montefiore Associate Benefits Program to recover medical or dental expenses paid to a participant for illness or injuries wrongfully caused by a third party or any illness or injury for which you and/or your family members are eligible to receive reimbursement from a third party.

Subrogation Agreement – A written agreement in which a covered individual agrees to reimburse the appropriate Plan for medical and/or dental benefits resulting from illness or injuries caused by a third party or any illness or injury for which you and/or your family members are eligible to receive reimbursement from a third party. The agreement must be signed by the associate and/or his or her family members, if applicable, before Plan payments are made to reimburse expenses incurred as a result of such illness or injury.

An Overview of Your Dental Options

You can waive coverage or select one of the following:

- Cigna Dental Health Maintenance Organization (DHMO)
- Preventive & Diagnostic Dental Care
- Cigna Dental PPO (DPPO)
- Cigna Enhanced DPPO.

Cigna Dental Health Maintenance Organization (DHMO)

Under the DHMO, if you use a network primary care dentist:

- Your out-of-pocket dental expenses are typically lower than under the other dental options
- You have no deductibles to pay
- There are virtually no claim forms to fill out, and
- You don't have to wait to be reimbursed (subject to certain limitations and exclusions).

If you select the DHMO, you choose a network primary care dentist for you and each enrolled family member. The dentist you select provides your dental care and will make referrals when appropriate to specialists within the DHMO network. No referral is needed to see a network orthodontist. As with the other dental options, there are restrictions on the frequency and/or age limitations of certain procedures.

You and your covered family members can choose the same network primary care dentist or you can select a different dentist for each. The DHMO network is nationwide, so even students away from home at school can choose their own network primary care dentist.

Cigna Preventive & Diagnostic Dental Care

Under this Option:

- You may visit any dentist. If you go outside of the Total Cigna Network, reimbursement levels are based on the Cigna Fee Schedule (not the Billed Charges). It does not affect the cost-sharing percentages for care established by the Plan. You may be balance billed for the difference between Billed Charges and the Cigna Fee Schedule.
- There are no deductibles, copayments or coinsurance to pay, and no annual maximum
- This plan covers Preventive & Diagnostic Services *only*; Basic, Major and Orthodontia services are not covered.

Cigna Dental (DPPO)

Under the DPPO Option, you may visit any licensed dentist or specialist without a referral. Plan participants have access to the Total Cigna Network (including Montefiore's Department of Dentistry). There is a $100 individual annual deductible for basic, major and orthodontic services combined. Each covered person has a $1,500 annual maximum benefit limit; however, you may increase your annual maximum benefit by $1,000 (up to $2,500) if you use a dentist in Montefiore's Department of Dentistry.

Cigna Enhanced DPPO

The Enhanced DPPO option, you have access to the same provider network as the Cigna Dental (DPPO) option with the following additional features:

- A $50 individual annual deductible for basic, major and orthodontic services combined
- Each covered person has a $2,500 annual maximum benefit limit
- Higher reimbursement levels for Major Restorative services.

Cigna Reimbursement Levels

In-network Benefits

Preventive & Diagnostic Dental Care, Cigna DPPO Dental Plan and Cigna DPPO Enhanced Dental Plan reimbursement levels are based on contracted fees with providers in the Total Cigna Network. These contracted fees lower your out-of-pocket costs. It does not affect the cost-sharing percentages for care established by the Plan. For example, if you use a network dentist for Basic Restorative Care, the Plan pays 80% and you are responsible for 20% of the contracted rate. You are not required to use these providers. However, you may save money if you do.

Out-of-network Benefits

If you go outside of the Total Cigna Network, reimbursement levels are based on the Cigna Fee Schedule. It does not affect the cost-sharing percentages for care established by the Plan. For example, if you visit a dentist outside of the network for Basic Restorative Care, the Plan pays 80% of the Cigna Fee Schedule (not the Billed Charges) and you are responsible for 20% of the Cigna Fee Schedule *plus* the difference between Billed Charges and the Cigna Fee Schedule.

The Deductible

The *deductible* is the dollar amount that you must pay *before* the Cigna DPPO Option or the Cigna Enhanced DPPO Option starts paying benefits for certain expenses. The $100 deductible under the Cigna DPPO, and the $50 deductible under the Cigna Enhanced DPPO, applies to each covered individual once each calendar year. Any amounts you pay toward *basic, major and orthodontic services* count toward satisfying the deductible.

Annual Maximum Benefit

Under the Cigna DPPO Option or the Cigna Enhanced DPPO Option, there is an annual individual maximum benefit for Preventive and Diagnostic, Basic and Major Services combined.

	Cigna DPPO	Cigna Enhanced DPPO
Individual Annual Deductible	$100	$50
Individual Annual Maximum Benefit	$1,500 $2,500 if you use a Montefiore Dentist	$2,500 regardless of the dentist you use

Covered Expenses

The following covered expenses and exclusions are highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your insurance certificate or plan description. If there are any differences between the information contained here and the plan documents, the information in the plan documents takes precedence.

Fee Schedules and Benefit Summaries are available on **www.mymontebenefits.com**.

- **DHMO Fee Schedule**
- **Cigna Preventive and Diagnostic Benefit Summary**
- **Cigna DPPO Benefit Summary**

Dental Services and Supplies	Your Cost:			
	Cigna DHMO	Preventive & Diagnostic Dental Care[1]	Cigna DPPO[1]	Cigna Enhanced DPPO[1]
Calendar Year Deductible: Individual/Family	None	None	$100/$300	$50/$100
Annual Maximum Benefits for each covered person for Preventive & Diagnostic, Basic and Major Services combined	None	None	$1,500 $2,500 if you use a Montefiore Dentist	$2,500 regardless of the dentist you use
Preventive & Diagnostic Services				
· Oral Exams · Cleanings · Routine X-Rays · Fluoride Application · Sealants · Space Maintainers (limited to non-orthodontic treatment) · Non-Routine X-Rays · Emergency Care to Relieve Pain	$0	$0[1]	$0[1]	$0[1]
Basic Restorative Services				
· Composite Fillings · Oral Surgery · Surgical Extraction of Impacted Teeth · Anesthetics · Major & Minor Periodontics · Root Canal Therapy/Endodontics · Brush Biopsy · Stainless Steel/Resin Crowns	30% coinsurance	Not covered	20%[1] coinsurance after $100 deductible	20%[1] coinsurance after $50 deductible
Major Restorative Services				
· Crowns/Inlays/Onlays – Dentures – Bridges · Relines, Rebases, and Adjustments · Repairs – Bridges, Crowns, Dentures, and Inlays · Prosthesis Over Implants	50% coinsurance	Not covered	50%[1] coinsurance after $100 deductible	40%[1] coinsurance after $50 deductible
ORTHODONTIC SERVICES				
· Comprehensive orthodontic treatment · Post treatment stabilization · Interceptive orthodontic treatment · Limited orthodontic treatment	50% coinsurance	Not covered	20%[1] coinsurance after $100 deductible	20%[1] coinsurance after $50 deductible
LIFETIME ORTHODONTIC MAXIMUM	None	Not covered	$2,000	$2,000

[1] In-network reimbursement levels are based on Contracted Fees.
Out-of-network reimbursement levels are based on the Cigna Fee Schedule. You may be balance billed for the difference between Billed Charges and the Cigna Fee Schedule.

Pre-Treatment Review (Cigna DPPO & Cigna Enhanced DPPO Options)

Pre-treatment review lets you know in advance how much the Cigna DPPO or Cigna Enhanced DPPO plan options will reimburse you when extensive dental work is expected.

Whenever your dentist recommends an elective dental procedure in excess of $200, you may want to have your dentist submit a proposed course of treatment to Cigna before the work begins.

Although the pre-treatment review procedure is not required, it can be helpful to you since many dental procedures are elective and some dental conditions can be treated in more than one way. When a condition can be treated in one of several ways, Cigna will base its payment on the least costly alternate procedure that is consistent with good dental care. Using a pre-treatment review can help to avoid a misunderstanding about what expenses will be reimbursed and let you know what portion of the cost you will be required to pay.

Alternate Treatment (DPPO, Enhanced DPPO & DHMO)

In some situations, there is more than one way to treat a particular dental condition in accordance with broadly accepted standards of dental practice. For example, either a crown or a filling might be used to restore a tooth. Both options are acceptable methods of correcting the problem. The difference lies in the cost.

Under the Alternate Treatment rule, the DPPO, Enhanced DPPO and DHMO will pay benefits for the procedure that provides the most effective long-term solution at the lowest cost – provided it is otherwise a covered service. (In this example, the filling would be the most cost-effective long-term solution.) However, you always have the option of permitting the dentist to perform the more expensive procedure, although you will be responsible for paying the difference in the cost.

Out-of-Area Emergency Treatment (DHMO)

If you or a covered family member is more than 50 miles from home and has a dental emergency, the DHMO will reimburse reasonable charges for palliative (pain relief or stabilization) expenses up to a maximum benefit of $100 for each separate emergency condition.

Maximum Benefits

If you elect the DHMO and obtain care from your network primary care dentist, there are generally no maximum benefit levels.

If you elect the Cigna DPPO Option, you and each covered family member can receive up to $1,500 in annual benefits for preventive and diagnostic, basic and major services combined. You can increase your annual maximum benefit by $1,000 (up to $2,500) if you use a dentist in Montefiore's Department of Dentistry. There is a separate individual lifetime maximum benefit of $2,000 for orthodontics.

If you elect the Cigna Enhanced DPPO Option, you and each covered family member can receive up to $2,500 in annual benefits for preventive and diagnostic, basic and major services combined, regardless of the dentists that you use. There is a separate lifetime maximum benefit of $2,000 for orthodontics.

However, some covered services are subject to separate limits and/or annual maximum benefits. These limits and maximums apply to each covered individual and are:

- Preventive & Diagnostic Services
  - Oral Exams – 2x/calendar year
  - Cleanings – 2x/calendar year
  - Routine X-Rays – Bitewings 2x/calendar year
  - Fluoride Application – 1x/calendar year up to age 19
  - Sealants – Limited to posterior tooth. One treatment per tooth/three years up to age 19
  - Space Maintainers (limited to non-orthodontic treatment)
  - Non-Routine – X-Rays
    - Full mouth: 1x/3 calendar years
    - Panorex: 1x/3 calendar years
- Major Restorative Services
  - Crowns/Inlays/Onlays – Replacement every 5 years
  - Dentures – Replacement every 5 years
  - Bridges – Replacement every 5 years
  - Relines, Rebases, and Adjustments – Covered if more than 6 months after installation
  - Repairs – Bridges, Crowns, Dentures, and Inlays –Reviewed if more than once

- Prosthesis Over Implants –1x/5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Exclusions

The Preventive & Diagnostic Dental Care Option will not pay for any services other than preventive and diagnostic care.

In addition, the Cigna DPPO, Cigna Enhanced DPPO and DHMO *do not* pay benefits for all dental services and supplies – even if recommended by a dentist. Expenses *not* covered include:

- Bite registrations; precision or semi-precision attachments; splinting;
- Dietary counseling, oral hygiene or dental plaque control training
- Duplicate prosthetic devices
- Educational, vocational or training services and supplies
- Expenses:
  - for filling out dental reports, bills, benefit request forms
  - in excess of reasonable and customary limits
  - incurred before you or one of your family members became a Dental participant
  - reimbursable under another employer's plan or any other source of payment
- Hospital charges
- Illness or injury – treatment of occupational illness or injury
- Plastic, reconstructive or cosmetic surgery – or other treatment – solely to improve, alter or enhance appearance unless needed to repair an injury
- Pontics, crowns, casts or processed restorations made with high noble metals
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Professional services provided by you, a family member or by someone who lives in your home
- Replacement of lost or stolen prosthetic devices

- Services and/or supplies:
  - for which there is no legal obligation to pay or charges that would not have been made except for the availability of benefits from this dental coverage
  - not necessary for the diagnosis, care or treatment of the condition involved – even if prescribed by a physician or dentist
  - not ordered or performed by a physician, dentist or other licensed dental practitioner
  - provided by the government, unless you are legally required to pay for the care you receive
  - provided outside the United States or its territories except for an emergency
  - that do not meet American Dental Association standards
  - which are primarily experimental/investigational in nature
- Veneers or facings on molar crowns and pontics.

Coordination of Benefits

Montefiore's Preventive & Diagnostic Dental Care Option and the Cigna DPPO and Enhanced DPPO Options contain a coordination of benefits (COB) feature. This feature applies when you or an eligible family member is covered by more than one group plan providing dental benefits. It limits combined benefits from all group dental plans to 100% of covered expenses subject to plan maximums. Under the coordination of benefits provision, the plan that has *primary* responsibility always pays *first*. The rules for determining which plan pays benefits first are the same as described in Non-Duplication of Benefits.

Claims should always be submitted to the primary plan first. Under the COB provision, you and your dependents can receive up to 100% of covered dental charges from all group plans combined – but no more than that.

If You Are Enrolled in the DHMO

The coordination of benefits feature does not apply to the DHMO. This means that the DHMO is always primary.

If You Continue to Work after Age 65

If you continue to work for Montefiore after you reach age 65, you and your enrolled family members, if you elect family coverage, will have the same dental options provided to active associates under age 65.

OTHER IMPORTANT INFORMATION ABOUT YOUR HEALTHCARE BENEFITS

What the Other Important Information About Your Healthcare Benefits Section Includes

GROUP HEALTH PLAN AS COVERED ENTITY

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

The Montefiore Medical Center Employee Health & Welfare Benefit Plan and the Montefiore Medical Center Retiree Benefit Plan (collectively, the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. The Plan does not exclude people or treat them differently because of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Plan Administrator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age, you may file a claim under the Plan. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the **Office for Civil Rights Complaint Portal**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **800.868.1019**, **800.537.7697** (TDD).

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-718-920-4943 (TTY: 1-718-920-5027).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-718-920-4943（TTY：1-718-920-5027）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718-920-4943 (телетайп: 1-718-920-5027).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718-920-4943 (TTY: 1-718-920-5027).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-718-920-4943 (TTY: 1-718-920-5027) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718-920-4943 (TTY: 1-718-920-5027).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-718-920-4943 (TTY: 1-718-920-5027).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-718-920-4943 (TTY: ১-1-718-920-5027)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-718-920-4943 (TTY: 1-718-920-5027).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-718-920-4943 (رقم هاتف الصم والبكم: 1-718-920-5027).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-718-920-4943 (ATS : 1-718-920-5027).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-718-920-4943 (TTY: 1-718-920-5027).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-718-920-4943 (TTY: 1-718-920-5027).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-718-920-4943 (TTY: 1-718-920-5027).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-718-920-4943 (TTY: 1-718-920-5027).

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Montefiore not to discriminate on the basis of race, color, national origin, sex, age or disability. Montefiore has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (**42 U.S.C. 18116**) and its implementing regulations at **45 CFR part 92**, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Maria Trotta-Williams, Assistant Director, Customer Service, 111 East 210th Street, Bronx, NY 10467, **718.920.4943**, **718.231.4262**, **civcilrightscoordinator@montefiore.org**, who has been designated to coordinate the efforts of Montefiore to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age may file a grievance under this procedure. It is against the law for Montefiore to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Montefiore relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator's decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the **Office for Civil Rights Complaint Portal**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: **www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Montefiore will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Claiming Healthcare Benefits

Claims should always be submitted to the primary plan first.

For Urgent Care Claims

If you file an urgent care claim, the Claims Administrator will make an initial benefit determination within 24 hours after they receive your properly completed claim form and all required documentation.

An urgent care claim is a claim filed before medical services are received and is for conditions in which receiving medical care quickly is a critical factor in:

- assuring the patient's life, health or ability to regain maximum function

  or

- in the opinion of a physician with knowledge of the patient's medical condition, avoiding severe pain.

If you file an incomplete urgent care claim, the following steps show the procedure and timing.

1. Within 24 hours after receiving your claim, the Claims Administrator will notify you that your claim is incomplete and tell you what information you need to provide.
2. You provide the requested information within the timeframe set by the Claims Administrator (but in no case less than 48 hours).
3. The Claims Administrator makes a final determination on the claim within 48 hours after:
   - You provide the requested information

     or

   - The end of the time period you have to provide the requested information

     . . . whichever is earlier.

If your claim is denied, you will receive notice of the denial as described in "**If Your Claim is Denied**". The initial denial of your urgent care claim may be provided orally. However, you will receive written notification of the denial within three days after the oral notification.

For Post Service Claims

If you file a post service claim, the Claims Administrator will send you written notification of their benefit determination within 30 days after receiving the claim. If matters beyond the control of the claims administrator require an extension of time, the Claims Administrator may extend the notification period by up to 15 days. If an extension is required, the Claims Administrator will notify you in writing before the end of the initial 30-day period. The notification will include the reasons the extension is required and the date by which the Claims Administrator expects to make its determination. If the extension is required because your claim was not complete, the notice of extension will describe the required information. You will have at least 45 days following receipt of the notice to provide the requested information.

A post service claim is a claim for benefits filed after the services are received.

Hospital Benefits

Generally, hospitals submit their bills directly to the Claims Administrator. If you do receive a hospital bill, make sure it is itemized and forward it to the Claims Administrator. If you or a covered family member is admitted to Montefiore, you should not receive a bill for the admission. If you do, do not pay it. Call the Montefiore billing department and identify yourself as covered under the Associate Benefits Program.

Laboratory Benefits

If you receive a bill for a covered expense directly from Quest Laboratories, LabCorp or any Montefiore hospital laboratory (including Moses, Einstein, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore Mount Vernon Hospital, Montefiore New Rochelle Hospital), do not pay the bill. Call the provider, identify yourself as covered under the Associate Benefits Program and instruct them to send the invoice to the Claims Administrator.

Vision Benefits

If you elect a UnitedHealthcare Vision Plan option, United HealthCare administers all claims. Vision care services you receive through an in-network provider generally require no claim forms.

If you receive services from an out-of-network provider, you pay the provider in full at the time of service and file a claim for reimbursement.

DHMO Benefits

If you elect the DHMO, Cigna administers all claims. Dental services you receive through the DHMO generally require no claim forms. Your primary care dentist will handle all of the necessary paperwork.

Other Benefits

Medical and dental services you receive through in-network providers generally require no claim forms. Your network provider will handle all of the necessary paperwork.

If you incur medical or dental expenses through out-of-network providers, you must file a claim to receive benefits. You should submit a claim for benefits when you or a covered family member incurs covered expenses in excess of any applicable deductible. Complete the associate portion of the form in full.

Attach all necessary documentation to the form:

- a description of the services and supplies provided with an itemized description of each charge
- the diagnosis and CPT 4 code, if applicable
- the date(s) of service
- the patient's name
- the provider's name, address, phone number and degree
- the provider's federal tax identification number.

Prescription Drugs

If you purchase prescription drugs at a non-participating pharmacy, you will be required to submit a claim form to receive benefits. Complete a Prescription Drug Claim Form and attach a copy of the receipt. The receipt must include the date, patient's name, prescription number, name of the prescription drug and quantity dispensed.

Claims Administration

The following table shows where claims should be submitted for different covered expenses.

To claim benefits for these healthcare expenses:	**Claims should be submitted to:**
· MonteCare EPO · MonteCare PPO	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 **866.236.6748**
· UnitedHealthcare Vision	UnitedHealthcare Vision Claims Department PO Box 30549 Salt Lake City, UT 84130-0549 **866.877.6187**
· Preventive & Diagnostic Dental Care · Cigna DPPO and Cigna DPPO Enhanced · Cigna Dental Health Maintenance Organization (DHMO)	Cigna Healthcare P.O. Box 188037 Chattanooga, TN 37422-8037 **800.Cigna24 (800.244.6224)**
· Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 **800.631.7780**
All claims must be submitted within 12-months of the date care was provided. Otherwise, no benefits will be paid.	

You must include the Name and Membership ID Number of the Montefiore associate on *all* claim forms submitted to the Claims Administrator – including claim forms provided to you by your physician and claims for covered expenses incurred by a dependent. Otherwise, your claim cannot be processed or paid. You should complete a *separate* claim form for each person for whom benefits are being requested. If another plan is the primary payer, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form.

For more information about claims and appeals, see "Claim Denials and Appeals" in the ERISA Additional Information Section of this SPD.

Termination of Coverage

Coverage under the Plan ends on the last day of the month in which:

- The Associate Benefits Program is terminated
- You no longer meet the eligibility requirements as an active associate
- You terminate your employment
- You fail to pay any required contributions as described under Continuation Coverage (COBRA).

If a dependent no longer qualifies as an eligible family member, coverage ends:

- For your dependent children – on the last day of the calendar year
- For your spouse or qualified domestic partner – on the last day of the calendar month.

Upon termination of coverage, you may be able to elect Continuation Coverage (COBRA) by paying the cost of coverage for a specified period of time.

General Notice of Cobra Continuation Coverage Rights

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their medical, dental, vision and health care flexible spending account benefits the right to choose to continue such benefits for limited periods of time under certain circumstances. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive coverage.

If coverage stops as a result of:

- Layoff, leave of absence, disability or termination of employment for reasons other than gross misconduct
- Retirement before age 65 if you do not qualify for retiree medical benefits
- A reduction in your regularly scheduled hours
- Divorce or legal separation or termination of a qualified domestic partnership
- A child no longer qualifying as a family member
- Your death

. . . you and/or your qualified beneficiaries can individually elect to continue coverage under the Montefiore medical, vision, dental and/or health care flexible spending account options you had in effect at the time of the qualifying event. Depending on the type of qualifying event, your spouse, qualified domestic partner and eligible dependent children may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries.

You will have the opportunity to change your options and coverage during the next fall annual election period. At that time, you will receive all the materials you need to make your elections. The decisions you make during the election period will take effect the following January 1.

Notifying the COBRA Administrator of Qualifying Events

You or your family members must notify Montefiore's HR-Benefits Office in writing if medical, dental, vision and/or health care flexible spending account coverage will stop due to any of the following events:

- you and your spouse are divorced or legally separated,
- your qualified domestic partnership terminates

  or

- a child no longer qualifies as a dependent.

You must send this written notification within 60 days after the date of the event or the date coverage would stop – whichever is later.

To elect continuation coverage, you must return the COBRA Election Form to the COBRA Administrator within 60 days after:

- You receive notice of your right to continue healthcare coverage

  or

- The date healthcare coverage stops, if later.

If you or a dependent initially waives COBRA continuation coverage, that individual may revoke that waiver during the 60-day COBRA election period. In that case, COBRA coverage will begin on the date you first became eligible provided you pay the required retroactive contributions on a timely basis.

Paying for COBRA Coverage

If you (or your family members) elect continuation coverage, you must pay 102% of the cost of coverage, as determined by the COBRA Administrator. If a disability occurs within the first 60 days of COBRA continuation coverage, the 18-month period for medical coverage may be extended up to 29 months as a result of the disability. The premium for the family may increase to 150% of the cost of coverage for the additional 11 months. While COBRA rates may seem high, you will be paying group premium rates, which are usually lower than individual rates.

You have 45 days after you elect COBRA coverage to pay the premium for the period beginning on the date COBRA coverage begins until the end of the month in which you return the COBRA election form. Claims under COBRA coverage will not be processed for this initial period until payment is received by the COBRA Administrator. After the initial payment, you must pay your monthly COBRA premium on the first day of the month. If not paid within 30 days of the date payment is due, coverage will automatically terminate without further notice. Claims under COBRA coverage will not be processed for any period until full payment is received by the COBRA Administrator.

Duration of COBRA Coverage

The following table shows the longest period of time coverage can be continued.

If you are:	And lose healthcare coverage due to one of the qualifying events shown below:	You can choose continuation of healthcare coverage for up to:
an MMC associate	· layoff, leave of absence (including military leave), or termination of employment (for reasons other than your gross misconduct) · a reduction in your regularly scheduled hours	18 months
	· disability (at the time of termination of coverage or within the first 60 days of continuation coverage)	29 months
a covered spouse or qualified domestic partner of an MMC associate	· your spouse or qualified domestic partner is on layoff, leave of absence, or terminates employment (for reasons other than gross misconduct) · a reduction in your spouse or qualified domestic partner's regularly scheduled hours	18 months
	· your spouse or qualified domestic partner is disabled at termination of employment or within the first 60 days of continuation coverage	29 months
	· the death of your spouse or qualified domestic partner · your spouse or domestic partner is disabled · divorce, legal separation, annulment or termination of a qualified domestic partnership	36 months
a covered dependent child of an MMC associate	· your parent is on layoff, leave of absence or terminates employment (for reasons other than gross misconduct) · a reduction in your parent's regularly scheduled hours	18 months
	· your parent is disabled at termination of employment or within the first 60 days of continuation coverage	29 months
	· the death of your parent · your parents' divorce, legal separation, annulment or termination of a qualified domestic partnership · you no longer qualify as a dependent for medical and dental coverage	36 months
Note: In no case, can COBRA coverage continue for more than 36 months, even if you experience multiple qualifying events.		

When the continuation period ends, healthcare benefits stop.

Continuation of healthcare coverage may be cut short if:

- You or your family members do not make all the required contributions on a timely basis

  or

- Montefiore terminates all health plans.

Continuation of your Medical coverage will also stop if you or your family members become entitled to Medicare (coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible).

If You Have Questions

For more information about your rights and obligations under the Plans and under federal law, you should contact the COBRA Administrator who is responsible for administering COBRA continuation coverage. The COBRA Administrator is:

WageWorks
PO Box 14053
Lexington, KY 40511
877.924.3967
ATTN: COBRA Department

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Program Informed of Address Changes

To protect your family's rights, you must notify the COBRA Administrator in writing of any changes in the addresses of family members. You should also keep a copy of any notices you send to the COBRA Administrator for your records.

Important Notice
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal privacy regulations to protect personal medical information went into effect on April 14, 2003 and were amended effective September 23, 2013 by the Health Information Technology for Economic and Clinical Health Act (HITECH). These privacy rules set limits on how health plans, pharmacies, hospitals, clinics, nursing homes and other direct-care providers (called covered providers) use individually identifiable health information.

This overview of HIPAA is intended to help you understand your rights and protection of personal information related to your health. Key HIPAA provisions include:

- ***Pre-existing Condition Limitations***
  - A pre-existing condition is one for which medical advice; diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date (the first day of health coverage or the first day of any waiting period for coverage, whichever is earlier).
  - Group health plans and issuers may not exclude an individual's pre-existing medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date.
  - Under HIPAA, a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more, reducing or eliminating the 12-month exclusion period (18 months for late enrollees)
- ***Certificate of Creditable Coverage*** – Creditable coverage includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan. You can use a certificate of creditable coverage to eliminate or reduce any pre-existing condition limitation period under another group healthcare plan. You can request a certificate of creditable coverage:
  - when you lose health coverage
  - when you become entitled to elect COBRA continuation coverage
  - when your COBRA continuation coverage ends
  - at any time before losing healthcare coverage

    or
  - up to 24 months after losing healthcare coverage.

- ***Prohibit Discrimination Based on Health Status*** – You or your family members may not be excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors
- ***Provide Special Enrollment R*ights** – You may request a special health plan enrollment under the following circumstances:
  - Within 30 days of the date:
    - you or a family member loses other group health plan coverage (such as a spouse's plan) or due to separation, divorce, death, termination of employment or reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates.
    - you acquire a new family member through marriage, birth, adoption or legal guardianship
  - Within 60 days of the date you or a family member:
    - are no longer eligible for coverage under the Children's Health Insurance Program (CHIP) or Medicaid
    - becomes eligible for premium assistance under the State's Children's Health Insurance Program (CHIP) or Medicaid.
- ***Limits on Identifiable Health Information***
  - Limits on Use of Personal Medical Information – The privacy rule sets limits on how covered providers (i.e., health plans, pharmacies, hospitals, clinics, nursing homes and other direct-care providers) may use your identifiable health information. These limits do not restrict the ability of healthcare professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to healthcare. Covered providers may use or share only the minimum amount of protected information needed for a particular purpose. In no case, will a covered provider use or disclose your personal medical information, which is genetic information for underwriting purposes.
  - You must provide written authorization for the following medical information to be disclosed:
    - Psychotherapy notes if maintained by the plan
    - Personal medical information for marketing purposes. For example, your written authorization will be required for the covered provider to share your medical information to promote health care products or services, alternative treatments, or provide appointment or treatment reminders. Your written authorization will not be required for prescription refill reminders, general health and wellness communications or communications about government or government-sponsored programs, such as eligibility for Medicare or Medicaid.

- Disclosures that constitute a sale of your personal medical information. A sale means that the covered entity receives direct or indirect remuneration in exchange for personal medical information. Your authorization is not required if remuneration for personal medical information is required to perform activities or provide service, such as research or for the services provided by the health information exchange.

- Personal health information released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your Healthcare.

- ***Access to Medical Records*** – HIPAA gives you the ability to review and obtain copies of your medical records. If your medical records are maintained electronically, you may request access to your electronic medical records, if that format is readily producible. Otherwise, the covered provider must provide the requested information in an electronic format that you can read on your computer (e.g., Word, Excel, etc.). You may also request corrections if you have identified any errors. Covered providers generally should provide access to your records within 30 days of your request and may charge for the cost of copying and sending the records to you.

- ***Notice of Privacy Practices*** – Covered providers will provide you with a HIPAA notice advising you of your rights. You may be asked to sign, initial or otherwise acknowledge that you have received this notice. You may also ask to restrict the use or disclosure of your information beyond the practices included in the notice, but the covered providers would not have to agree to the changes. Individuals who pay their providers by cash can instruct their provider not to share information about their treatment with their health plan.

- ***Confidential communications*** – Under the privacy rule, you can request that your doctors, health plans and other covered providers take reasonable steps to ensure that their communications with you are confidential. For example, you could ask your doctor to call you at work rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.

- ***Stronger State Laws*** – The federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; any state law providing additional protections would continue to apply. When a state law requires a certain disclosure – such as reporting an infectious disease outbreak to the public health authorities – the federal privacy regulations would not preempt the state law.

- ***Complaints*** – You may file a formal complaint regarding Montefiore privacy practices to:

  Health Plan Privacy Officer
  HR – Benefits Office
  Montefiore Medical Center
  111 East 210th Street
  Bronx, NY 10467-2490
  Telephone: **914.349.8531**

Complaints may also be made in writing to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation.

- ***For More Information*** – If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at **866.444.3272**. You can find additional HIPAA information on the Internet at **www.hhs.gov/ocr/hipaa**.

Genetic Information Non-discrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act prohibits discrimination in health coverage and employment based on genetic information. GINA, together with provisions of the Health Insurance Portability and Accountability Act (HIPAA), generally prohibits health insurers or health plan administrators from requesting or requiring genetic information of an individual or an individual's family members, or using this information for decisions regarding coverage, rates, or preexisting conditions. GINA also prohibits employers from using genetic information for hiring, firing, or promotion decisions, and for any decisions regarding terms of employment.

Surcharge

New York State has imposed an 8.18% surcharge on certain medical expenses. Montefiore has made arrangements to pay this surcharge directly to the State. If you receive a bill that itemizes the surcharge, do not pay this charge. Notify the provider that Montefiore participates in the New York State Department of Health Public Goods Pool.

It is important for you not to make this payment since Montefiore has already made this payment for you. The Claims Administrator will not reimburse you for this charge. If you have paid this surcharge, you should contact the provider for a refund. You can ask the Claims Administrator to send a letter to the provider confirming that the Claims Administrator has paid the surcharge to the State.

Subrogation

This provision applies if you and/or your covered family members become ill or are injured as a result of the intentional action or negligence of a third party or any illness or injury for which you and/or your dependents are eligible to receive reimbursement from a third party. In that case, you must sign an agreement known as a Subrogation Agreement, to reimburse the Montefiore Associate Benefits Program from whatever moneys are recovered from the third party (whether an individual or insurance company is liable) as a result of a court judgment, settlement or otherwise. Here is an example of how subrogation works.

If you were hurt as a result of another person's negligence, the individual – or his or her insurance company – might compensate you for your injury. In that case, you would be required to repay any amounts the Plan had advanced to you and/or your covered family members for medical and/or dental expenses resulting from such illness or injuries. The repayment must equal the benefits you received from the Plan less reasonable expenses to make the recovery.

You must take whatever actions are required by the Plan Administrator and/or the Subrogation Agreement to enforce the subrogation right of the plan. Failure to cooperate in the enforcement of this Agreement, including the failure to repay the Plan from the judgment or settlement proceeds, may lead to the suspension of any further benefits you and any of your family members may receive under the plan.

Qualified Medical Child Support Orders (QMCSO)

Federal law requires group health plans to honor qualified medical child support orders (QMCSOs).

In general, a QMCSO is a state order or directive requiring a parent to provide medical support to a child in case of separation or divorce and under certain statutory conditions. Upon receipt of a medical child support order (MCSO), the Plan Administrator will notify you and the affected child that it is reviewing the order to determine if it is qualified and the procedures used to determine whether the order is qualified. If the Plan Administrator determines that the order is qualified, the Associate medical option is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. However, the child must be enrolled and the associate must be making any required contributions. For further information, contact Montefiore's HR-Benefits Office.

Occupational Health Services (OHS)

You also have access to Occupational Health Services (OHS). Montefiore's Occupational Health Services Department offers the following services:

- Free annual assessments including tuberculosis and diabetes screening (A1C testing – fasting is not required) and influenza vaccinations
- Nutrition Counseling Service – One-on-one, confidential counseling to help you manage your weight, lower your health risks, enhance your life and eat wisely
- Smoking Cessation Programs – Provides information on nicotine replacement therapy and offers a no-cost nicotine replacement therapy starter kit through Montefiore's outpatient pharmacies
- Montefiore provides a lactation-friendly environment and supports mothers who continue to breastfeed after returning to work from maternity leave. Associate Lactation Suites are located at the Moses, Wakefield and Einstein Campuses.

HealthCare Employee Assistance Program

The HealthCare EAP provides assistance to you or members of your immediate family if you have a personal problem, such as marital, parent-child, legal or financial difficulties, stress, depression, anxiety, grief reactions, substance abuse, or any other emotional or behavioral problem. Assistance is provided on a strictly confidential basis, through a staff of experienced counselors from various disciplines. These include sociologists, substance abuse counselors, social workers, and a session psychiatrist.

The HealthCare EAP is provided at no cost to you through ESI/Longview Associates **800.666.5EAP (5327)** **www.MyHealthCareEAP.com.**

Care Guidance

The Care Guidance Program provides you with a Personal Health Nurse (PHN) who will work one-on-one with you for as long and as often as you need. This is a voluntary program that can provide support and resources to help you, or a member of your family, manage your or their health. Montefiore provides this program at no cost to Montefiore associates and their family members who are covered by Montefiore's Empire BlueCross BlueShield medical plans. All services are completely confidential.

Working as a team, your physician and your PHN will set health goals, create an action plan and identify ways to help you maintain healthy habits. Your PHN's goal is to efficiently guide you through the different aspects of the healthcare system, making your care manageable and more successful.

You are requested to voluntarily pre-certify Care Guidance if you or a covered family member is admitted to the hospital for any reason (e.g. medical, surgical, behavioral health, substance abuse, maternity, skilled nursing and rehabilitation services). This will allow Care Guidance to work with you at critical points in your care, help answer questions and help you follow your doctor's course of treatment.

You should notify Care Guidance:

- 14 days before a non-emergency inpatient admission
- Within 48 hours or as soon as reasonably possible after an emergency admission.

Call **855.MMC.WELL (855.662.9355)** or email **mmccareguidance@montefiore.org**

FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts allow you to pay for certain eligible expenses with dollars that are *never taxed*. They also expand your benefit program and strengthen the level of your coverages by reimbursing you for expenses which may not otherwise be covered under other plans.

There are two accounts – one for healthcare expenses and one for dependent care expenses. The FSA, funded with before-tax contributions deducted from your pay, lower your taxable income by allowing you to pay *less*:

- Federal income tax
- Social Security tax (on your earnings below a certain level)
- Medicare tax

  and

- State and local income taxes in many states, including New York and Connecticut (but not in New Jersey).

What the FSA Section Includes

Glossary of Key Terms

Annual Base Salary – Your annual base rate of pay including any tax-deferred contributions that you make to a qualified or non-qualified plan sponsored by Montefiore, for example, the Montefiore Voluntary Tax Deferred Annuity 403(b) Plan, but excluding differentials, bonuses, overtime pay and any other forms of extra compensation.

Before-tax Contributions – The amount(s) you elect to have deposited into your Healthcare and/or your Dependent Care Accounts. These contributions come out of your pay before it is taxed, thereby reducing your taxable income.

Eligible Dependent Care Expenses – Those expenses you incur to provide day care to your eligible dependents so that you and, if you are married, your spouse can work or look for work.

Eligible Dependents

- Healthcare Account – Your spouse and any individuals you claim as a dependent on your federal income tax return – as well as children to age 26, regardless of whether they are dependent upon you – and whether or not they are enrolled in Montefiore's medical or dental plans
- Dependent Care Account – Your children prior to their 13th birthday and/or physically or mentally incapacitated individuals age 13 and older whom you claim as dependents for income tax purposes.

Eligible Healthcare Expenses – Those expenses considered tax deductible by the Internal Revenue Service (IRS).

WageWorks – The Claims Administrator for Flexible Spending Accounts.

Your Flexible Spending Accounts

Two Flexible Spending Accounts are available to you.

- The Healthcare Account is used to pay you for unreimbursed healthcare expenses for you and your eligible family members – i.e., those expenses that you pay out of your own pocket. These may include deductibles, coinsurance, copayments, amounts above reasonable and customary limits, and other unreimbursed medical, dental, vision, and hearing expenses. You cannot use this account to pay for health insurance premiums.
- The Dependent Care Account is designed to help address work and family issues. This account is used to reimburse you for eligible dependent care expenses if that care is necessary so that you can work. If you are married, the care must also allow your spouse to work or attend school on a full-time basis.

Only expenses incurred while you are making contributions to the FSA are eligible for reimbursement.

How Flexible Spending Accounts Save You Money

Assuming a 25% federal income tax bracket, you will save *at least* 34.65% in taxes on your contributions to an FSA. This is because your contributions are not subject to the 7.65% Social Security/Medicare tax or federal income tax of 25% (or more). The higher your federal income tax bracket, the more you will save in taxes. Also, in many states, you will save on state and local income taxes. The following table gives some examples.

	25% TAX BRACKET	**28% TAX BRACKET**	**33% TAX BRACKET**
If You Contribute This Much In One Calendar Year	**You Save This Amount in Taxes**[1] (assumes savings of 7.65%[2] in SS/Medicare taxes + 25% in federal income taxes)	**You Save This Amount in Taxes**[1] (assumes savings of 7.65%[2] in SS/Medicare taxes + 28% in federal income taxes)	**You Save This Amount in Taxes**[1] (assumes savings of 7.65%[2] in SS/Medicare taxes + 33% in federal income taxes)
$130	$42.45	$46.35	$52.85
$500	$163.25	$178.25	$203.25
$1,000	$326.50	$356.50	$406.50
$1,500	$489.75	$534.75	$609.75
$2,000	$653.00	$713.00	$813.00
$2,500	$816.25	$891.25	$1,016.25
$3,000	$979.50	$1,069.50	$1,219.50
$4,000	$1,306.00	$1,426.00	$1,626.00
$5,000	$1,632.50	$1,782.50	$2,032.50

[1] Not included are state or local income taxes, if any.

[2] The Social Security tax rate drops to 1.45% for earnings over the Social Security wage base, which for 2017 is $127,200.

Your Contributions

When you enroll, you decide how much, if anything, to contribute to your Flexible Spending Accounts. You will need to make a separate election for each account.

- **Healthcare Account:** You can make an annual contribution from $130 to $2,550.
- **Dependent Care Account:** You can make an annual contribution from $130 to $5,000 ($2,500 if you and your spouse file separate tax returns). If you or your spouse has an annual taxable income of less than $5,000, your contribution would be limited to the lesser of the two incomes. The IRS imposes a $5,000 annual maximum limit for combined family contributions to dependent care accounts.

  If your spouse is either a full-time student or incapable of self-care, your spouse will be considered to have an annual income of $3,000 if you have dependent care expenses for one child, or $6,000 if you have expenses for two children.

Special Rules to Consider

The following rules are important to keep in mind so that you obtain the maximum possible value from Flexible Spending Accounts.

- Once you establish a Healthcare Account, it cannot be canceled or reduced during the year.
- Once your contributions begin, the government will not allow them to be changed during the year unless you experience a qualified change in status. Whatever amount you select for either or both accounts must continue until year-end. Transfer of money between the two accounts is *not* permitted.
- To reduce the possibility of forfeitures, IRS rules permit you to apply eligible expenses incurred through March 15th against any remaining balance in your prior year's Healthcare or Dependent Care Account.
- If you are newly eligible or have a qualified change in status and enroll in a Healthcare and/or Dependent Care Account during the year, only expenses incurred while you are making contributions to the accounts are eligible for reimbursement. You cannot obtain reimbursement for expenses incurred before your account contributions begin or after they stop.
- The IRS requires that any amounts remaining in your account(s) after April 30th of the following year must be forfeited. In return for a significant tax advantage when you use your FSA, the government prohibits Montefiore from returning unused FSA contributions. However, there is a four-month "grace period" that gives you until April 30th of the following year to submit claims for expenses up to your account balance. Keep in mind, however, that even with a small forfeiture you may still come out ahead using the FSA because of the tax savings.

  For example, let's assume you estimate that your out-of-pocket healthcare expenses will total $900 during the year. However, the total of your *actual* out-of-pocket expenses reach only $875. The $25 difference ($900 - $875 = $25) is *forfeited*. To the extent your tax savings are greater than the amount you forfeit, you can still come out ahead.

Discrimination Testing

FSA tax-favored benefits are available only if certain criteria and nondiscrimination tests are met each year. A plan may be deemed discriminatory if qualified benefits are disproportionately received by highly compensated/key participants. If a plan is found to be discriminatory, the amount contributed by highly compensated/key participants is no longer tax-qualified under the plan and must be included in taxable gross income.

Eligible Healthcare Expenses

You can be reimbursed for those healthcare expenses considered tax deductible by the IRS. The IRS does not allow a tax deduction on your federal tax return if you have been reimbursed from your account for the same expenses. Also, you cannot be reimbursed for any expenses that are paid for by any other health plan (including Montefiore's), which covers you or your family.

Subject to IRS rules, eligible healthcare expenses may include:

- Abortion
- Acupuncture performed by a licensed practitioner
- Alcoholism and drug addiction – inpatient treatment at a therapeutic center including meals and lodging at the center during the treatment; transportation to and from local meetings of Alcoholics Anonymous, if medically necessary for treatment of alcoholism
- Ambulance service
- Artificial limbs and teeth
- Bandages
- Birth control pills prescribed by a physician
- Braille books and magazines – the difference in cost of regular printed editions
- Breast reconstruction – following a mastectomy for cancer
- Capital expenses for installation of special equipment or other home improvements to accommodate a disability
- Car hand controls or other special equipment installed for the use of a person with a disability
- Charges which exceed usual, reasonable and customary limits
- Contact lenses for medical reasons and equipment and materials for their use
- Copayments, coinsurance and deductibles
- Cosmetic surgery to improve a congenital abnormality, injury resulting from an accident or trauma, or a disfiguring disease
- Crutches – purchase or rental
- Dental expenses not covered by insurance – X-rays, fillings, orthodontia, extractions, dentures, etc. (but not teeth whitening)
- Diagnostic devices – used in diagnosing and treating illness and disease (i.e., blood sugar testing kit)
- Eyeglasses for medical reasons – lenses, frames, exams, prescribed sunglasses
- Eye surgery to treat defective vision – radial keratotomy, laser surgery
- Fertility enhancement – in vitro fertilization, procedures to reverse sterilization

- Guide dog or other specially trained animal used by a visually or hearing-impaired person
- Hearing aids and batteries
- Hospitalization for medical care – including private room coverage
- Insurance premiums – for policies paid on an after-tax basis
- Laboratory fees
- Lactation expenses
- Lead based paint removal
- Legal fees to authorize treatment for mental illness
- Lifetime care – advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically impaired dependent
- Long Term Care premiums (maximum limits apply) and unreimbursed expenses for qualified long term care services
- Medical conferences – admission and transportation expenses for conferences on chronic illnesses affecting you or your dependents
- Medical information plan – fees paid to a plan maintaining an individual's medical information by computer
- Medical services provided by physicians, surgeons, specialists or other medical practitioners
- Medicines – prescribed and legally obtained drugs and medicines
- Nursing home confinement for treatment of illness or injury
- Over-the-counter drugs and medications with a doctor's prescription, to treat an illness or injury (e.g., antacids, allergy medicines, pain relievers, and cold medications)
- Over-the-counter medical supplies, to treat an illness or injury (e.g., bandages, contact lens solution, first aid supplies, and reading glasses)
- Organ transplants for the donor
- Oxygen to relieve breathing problems caused by a medical condition
- Professional services for care related to a patient's condition provided by an Allergist, Chiropractor, Christian Science Practitioner, Dermatologist, Homeopath, Mid-Wife, Naturopath, Nurse (Registered or Licensed Practical Nurse), Ophthalmologist, Optometrist, Osteopath, Physician, Psychiatrist, Psychologist, Physical, Speech or Occupational Therapist

- Special education – special schooling recommended by a doctor for a specially trained and qualified teacher to work with children with learning disabilities due to physical or mental impairments
- Special home for a mentally retarded individual to adjust from life in a mental hospital to community living, on advice of a psychiatrist
- Sterilization
- Stop-smoking programs
- Surgery – including experimental procedures
- Telephone – special equipment for the hearing impaired
- Television – audio display equipment for the hearing impaired
- Transplants
- Transportation and travel expenses for medical care
- Vaccinations and immunizations
- Vasectomy
- Vision correction surgery
- Vitamins, herbal supplements, natural medicines and nutritional supplements recommended for the treatment of a specific medical condition
- Weight loss programs for treatment of a specific disease diagnosed by a physician (i.e., obesity, hypertension or heart disease)
- Wheelchairs for the relief of sickness or disability, and not just to provide transportation to and from work
- Wig – if recommended by a physician for the mental health of a patient who has lost all of his/her hair as a result of disease.
- X-ray fees for medical reasons.

Letter of Medical Necessity

Certain healthcare expenses may require a Letter of Medical Necessity from your provider when you submit claims in order to determine if your expenses qualify for reimbursement.

Products and services that may require a Letter of Medical Necessity are:

- Alternative healers, dietary supplements, drugs, medicines and treatment products
- Braille books and magazines (difference in cost only)
- Breast pump (to compensate for a medical condition)
- Car modifications, Exercise equipment or program, Fitness programs, Health club dues, Home improvements (for a medical condition diagnosed by a licensed healthcare professional)
- Cord blood storage (for future treatment of a birth defect or known medical condition)
- Dancing lessons
- Dental veneers
- Dietary supplements
- Humidifier, air filter and supplies
- Lodging (essential to receive medical care)
- Massage therapy
- Modified equipment (difference in cost only)
- Nutritional supplements
- Orthopedic shoes and inserts (difference in cost only over like non-specialized shoe)
- Propecia
- Reconstructive surgery (following accident, medical procedure or condition)
- Retin-A (for non-cosmetic purposes)
- Special equipment
- Special foods (for treatment of a medical condition; difference in cost only)
- Special school (for mental and physical disabilities)
- Swimming lessons
- Weight loss counseling, program or drugs.

IRS Publication 502 contains a complete list of healthcare expenses eligible for reimbursement. The publication is available free of charge by calling the IRS at **800.829.3676**. It is also available on the Internet at **www.irs.gov/pub/irs-pdf/p502.pdf.**

Healthcare Expenses Not Eligible

Expenses *not* eligible for reimbursement include:

- Babysitting, child care or nursing services incurred in connection with the care of a normal, healthy newborn (even though the care may be required due to the death of the mother during childbirth)
- Contributions to a Health Savings Account (HSA) or Medical Savings Account (MSA)
- Cosmetic surgery, electrolysis/hair removal, hair transplant, hair loss treatment, face lift, teeth whitening or liposuction to improve appearance
- Cost of sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods
- Custodial care in an institution
- Expenses reimbursed by a Health Reimbursement Arrangement (HRA)
- Fees for exercise, athletic, health or fitness club dues, exercise equipment
- Funeral and burial expenses
- Future medical care
- Household and domestic help – even if recommended by a physician because of an inability to perform household work
- Illegal operations, treatments or controlled substances in violation of federal law
- Insurance premiums for hospitalization or medical care – paid on a before-tax basis or paid by the Medical Center
- Marriage or family counseling
- Maternity clothing or diaper service
- Medicines and drugs from other countries
- Over-the-counter medications without a doctor's prescription, vitamins, natural foods, dietary supplements or homeopathic medications to improve general health or well-being
- Personal use items such as cosmetics or toiletries
- Social activities (i.e., swimming, dancing) – even if recommended by a physician
- Transportation expenses to and from work – even if a physical condition requires special means of transportation
- Vacation or travel – even when taken for general health purposes
- Veterinary fees
- Weight loss programs and diet food items to improve appearance.

Eligible Dependent Care Expenses

Eligible dependent care expenses are those necessary for you to work or look for work. (If you are married, your spouse must also work outside the home, be registered as a full-time student or physically or mentally incapacitated.) You can be reimbursed for care provided for a qualified dependent – i.e., anyone you claim as a dependent on your tax return, including children prior to their 13th birthday and/or physically or mentally incapacitated individuals age 13 and older whom you claim as dependents for federal income tax purposes.

You can be reimbursed for those dependent care expenses considered tax deductible by the IRS. The IRS does not allow a tax deduction on your federal income tax return if you have been reimbursed from your account for the same expenses.

Subject to IRS rules, eligible dependent care expenses provided in your home or through an outside source include:

- Babysitter, Nanny, Au pair, Housekeeper (only the portion attributable to work-related child care)
- Before-school or after-school programs for children under age 13
- Custodial elder care (if primarily for work-related dependent care)
- Day care center – child or adult (if the center provides day care services for more than six persons, it must comply with all state and local laws)
- Pre-school, nursery school or similar programs for children below the level of kindergarten
- Sick child care
- Summer day camp.

Dependent Care Expenses Not Eligible

Dependent care expenses *not* eligible for reimbursement include:

- Activity, late payment or registration fees
- Babysitting (weekend or “evening out”)
- Care provided by someone you claim as a dependent on your federal income tax return, or your child under age 19
- Custodial elder care (not work-related)
- Educational, learning or study skill services, tutoring, field trips
- Household services (housekeeper, maid, cook, etc.)
- Institutional care, such as nursing home services
- Kindergarten or private school tuition
- Language classes, piano or dance lessons
- Meals, food or snacks
- Medical care
- Overnight summer camp
- Transportation to and from eligible care (not provided by your care provider).

In addition, dependent care expenses you prepay in one calendar year for services rendered in the next calendar year are *not* eligible for reimbursement through the Dependent Care Account – even if the expense would have been eligible had it been provided and paid for in the same calendar year.

IRS Publication 503 contains a detailed explanation of eligible and ineligible dependent care expenses. It is available free of charge by calling the IRS at **800.829.3676**. It is also available on the Internet at **www.irs.gov/pub/irs-pdf/p503.pdf**.

Dependent Care Account Versus the Federal Tax Credit

You are eligible for a credit on your federal income taxes for dependent care expenses similar to those that can be reimbursed through the Dependent Care Account. You cannot use both methods to gain a "double" tax advantage on the same expenses. You can use one or the other; or apply the tax credit to some expenses and use the Dependent Care Account for others. However, maximum expenses for the tax credit calculation ($3,000 for one dependent, $6,000 for two or more dependents) are reduced dollar for dollar by reimbursements made through the Dependent Care Account.

For example, if you have two children, spend $6,000 a year for childcare and are reimbursed $2,600 from the Dependent Care Account, the maximum tax credit available to you is $3,400 ($6,000 maximum tax credit *minus* $2,600 received from the account). If you received $5,000 from the account, your maximum tax credit would be $1,000.

In some situations, using the Dependent Care Account will produce a greater advantage. In others, the tax credit will be more valuable. Your particular situation will determine which is better for you and you should do a direct comparison.

Annual Limit

The IRS imposes a $5,000 annual maximum, which applies to all Dependent Care Accounts combined. For example, the $5,000 annual maximum would apply if:

- You and your spouse each elect a Dependent Care Account (whether or not you both work for the same employer)
- You change jobs during the year and establish a Dependent Care Account with both employers
- You and your spouse (if married) file a joint tax return
- Your earned income, or if you are married, the lesser of your earned income or that of your spouse, is at least $5,000.

Dependent Care Reporting Requirements

It is important to note that to use the tax credit or the Dependent Care Account you *must report* the name, address and taxpayer identification number of your dependent care provider on Form 2441 which is submitted as part of your individual tax return. If the organization providing care is exempt from paying federal taxes, you are still required to report their name and address.

Claims Reimbursement

WageWorks is the Claims Administrator for Healthcare and Dependent Care Flexible Spending Accounts. WageWorks (**www.wageworks.com**) provides a variety of ways to access the funds in your accounts, such as:

- WageWorks Healthcare Card – The Healthcare Card may be used to pay for eligible healthcare expenses, such as prescription co-pays or co-pays for visits to your doctor. Simply present your Card to the provider at the time of service. The Healthcare Card will carry your current year account balance.
  - When you use your WageWorks Healthcare Card with an automatic payment machine it is considered a credit card transaction – no PIN number is required. Although it's called a debit card – because funds are deducted directly from your Healthcare Account – you must select the credit button when you swipe your card.
  - Your Healthcare Card will only be accepted at merchants who have a special system designed to work with the Card. The Information Inventory Approval System (IIAS) automatically verifies the eligibility of your purchase at checkout. However, in some situations, for example when you use the Card at a doctor's office or hospital, you may still be required to verify card transactions and submit a receipt along with a Card Use Verification Form to WageWorks. It is extremely important that you save all receipts as the IRS requires 100% verification of all Healthcare Card transactions.
- Pay My Provider – You can generate automatic online payments to your providers with checks drawn directly from your accounts.
- Pay Me Back Claim Forms – Reimburse yourself via check or direct deposit using a Pay Me Back Claim Form. You can fax it to a toll-free number (**877.353.9236**), or mail it in to:

  Claims Administrator
  PO Box 14053
  Lexington, KY 40511

  Be sure to attach copies of all bills, Explanations of Benefits (EOBs), itemized vendor receipts and/or statements to the claim form. Credit card receipts, canceled checks and other non-itemized receipts do not meet the requirements for acceptable documentation.
  - Healthcare attachments must include the name of the patient, the date the service was rendered, the name of the service provider, the type of service(s) and the amount charged.
  - Dependent Care attachments must include an itemized statement from the dependent care provider that includes: service dates, dependent's name, type of service, amount billed and provider's name, address and taxpayer identification number.

If you request reimbursement of an amount greater than your:

- Healthcare Account balance and your claim is accepted – it will be paid in full – up to the amount you have agreed to contribute for the year less amounts already paid to you during the year.
- Dependent Care Account balance and your claim is accepted – you will be paid only up to the amount in your account at that time. However, eligible expenses above the amount in your account will be paid upon receipt of additional contributions up to the maximum amount you elected prior to the beginning of the Plan year provided you file another claim.

If you have a change in status and increase contributions to an existing account, expenses incurred prior to the status change that exceed the original amount of your election are not eligible for reimbursement.

You should retain any receipts associated with eligible healthcare or dependent care expenses, as WageWorks may periodically ask for documentation of expenses to comply with IRS audit requirements.

If you submit claims to your FSA for a qualified same sex domestic partner, WageWorks may require you to submit a copy of your federal income tax return. If the individual does not qualify as your dependent for federal income tax purposes, expenses are not eligible for reimbursement through an FSA.

Other Important Information

If You Leave Montefiore

HEALTHCARE ACCOUNT – COBRA CONTINUATION

If you leave Montefiore, you can continue to submit claims for expenses incurred through the date you terminate (up to the amount you have agreed to contribute for that year, less amounts already paid to you).

You can also elect to continue contributions to your Healthcare Account on an *after-tax* basis. If you do, you can continue to submit claims through that account for eligible expenses incurred from the date you terminate until the end of that calendar year.

Any unused balance remaining in your account after all claims have been submitted will be forfeited.

DEPENDENT CARE ACCOUNT

If you leave Montefiore, all contributions to your Dependent Care Account stop. However, you can continue to submit claims for expenses incurred through the date you terminate – up to the balance remaining in your Dependent Care Account.

In Case of Your Death

HEALTHCARE ACCOUNT

If you die with a Healthcare Account balance, your surviving spouse or qualified domestic partner – or the administrator of your estate – can continue to submit claims for expenses incurred through the date of your death – up to the amount you have agreed to contribute for that year, less any amounts already paid to you.

Your spouse or qualified domestic partner may also elect to continue contributions to your Healthcare Account on an after-tax basis and submit reimbursement requests for eligible expenses incurred that calendar year.

DEPENDENT CARE ACCOUNT

If you die with a Dependent Care Account balance, your surviving spouse, qualified domestic partner or the administrator of your estate can continue to submit claims for expenses incurred through the date of your death – up to the amount you contributed prior to your death, less any amounts already paid to you.

GROUP LEGAL SERVICES

This coverage helps pay all or part of the costs for a wide range of personal legal services for you and your covered family members. If you use an in-network lawyer, full payment is provided for many services while a scheduled amount applies to others. You can choose any lawyer you want although a greater portion of your cost is generally paid if you use the services of an in-network lawyer.

What the Group Legal Section Includes

Glossary of Key Terms

In-network Lawyer (Plan Attorney) – is a lawyer – within a network established by Hyatt Legal Plans – who has agreed to accept the Plan's benefit as payment *in full* for covered legal services. Services that are not covered in full are paid according to a fee schedule.

Your Group Legal Services Options

You can elect to cover yourself alone *or* you and your eligible family members *or* elect no coverage.

Making Use of the Service

To use the Legal Plan, call Hyatt Legal Plans' Client Service Center at **800.821.6400** between 8 a.m. and 8 p.m., Monday through Friday. The Client Service Representative who answers your call will:

- verify your eligibility for services
- make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage)
- give you an authorization number which is similar to a claim number (you will need a new authorization number for each new case you have)
- give you the telephone number of the Plan Attorney most convenient to you

  and

- answer any questions you have about the Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you.

You may also access the Plan through Hyatt's Web Site: **www.legalplans.com**. You will be prompted for a password – type in 3700010 for family coverage or 3710010 for single coverage. If you are enrolled, you may obtain your own authorization number by inserting your Social Security Number.

If you choose, you may select your own attorney. In areas where there are no participating law firms, you will be asked to select your own attorney. In both of these circumstances, Hyatt Legal Plans will reimburse you for these non-plan attorneys' fees in accordance with a set fee schedule.

Please contact Hyatt Legal Plans *prior* to contacting any attorney.

Covered Services

The following personal legal services are *fully* paid for by the Plan when you see a Plan Attorney. There are no limits on the number of times you may use the Plan, and there are no dollar limits on your use of a Plan Attorney for the following services:

- Wills and Estate Planning
  - Living Wills
  - Powers of Attorney
  - Wills and Codicils
  - Trusts
- Traffic Matters
  - Traffic Defense, excluding "Driving Under the Influence" (DUI)
  - Driving Privileges Restoration
- Real Estate Matters
  - Eviction Defense
  - Tenant Negotiations
  - Sale or Purchase of Home
- Consumer Protection
  - Small Claims Assistance
- Debt Matters
  - Debt Collection Defense
  - Personal Bankruptcy
  - Identity Theft
- Defense of Civil Lawsuit
  - Administrative Hearings
  - Civil Litigation Defense
- Document Preparation
  - Affidavits
  - Deeds
  - Mortgages
  - Notes
- Document Review
  - Any personal legal document
- Family Law
  - Prenuptial Agreements
  - Name Change
  - Uncontested Adoption
  - Uncontested Guardianship
- Juvenile Matters
  - Juvenile Court Defense (Dependent Only)
- Personal Injury
  - Personal injury matters at a maximum fee of 25% of the gross award
- Probate
  - Probate matters at a fee 10% less than the prevailing fee

Unlimited Telephone Advice and Office Consultation

Telephone advice or office consultation is available for any legal service, except those specifically listed as excluded.

The following fee schedule describes the maximum amounts that Hyatt Legal Plans will reimburse you for covered legal services provided to you by an attorney not on their panel. Only one fee category per case type applies to each matter – i.e., the one that best describes the services that were provided. The Legal Plan provides only for the following personal legal matters listed. If you or your attorney has any questions regarding coverage or exclusions, please call **800.821.6400** and speak with a Client Service Representative.

CASE TYPE	The Plan will Pay Up to a Maximum of:
ADVICE AND CONSULTATION	
Office Consultation and Telephone Advice (If no further covered services are provided)	$50
CONSUMER PROTECTION	
Plaintiff Consumer/Consumer Protection Matters (Excludes disputes over real estate, construction or insurance. Disputed amount exceeds small claims limit and is evidenced by writing)	
· Correspondence & Negotiation	$150
· Filing of Suit, Ending in Settlement	$350
· Filing of Suit, Ending in Judgment	$750
· Plus Trial Supplement*	$10,000
DEBT MATTERS	
Debt Collection Defense (Excludes defense of matters arising from divorce or post-decree actions. Includes repossession and garnishment)	
· Negotiation and Settlement	$250
· Trial	$1,000
· Plus Trial Supplement*	$10,000
DEFENSE OF CIVIL LAWSUITS	
Administrative Hearing and Incompetency Defense (Excludes defense of matters arising from divorce or post-decree actions)	
· Negotiation and Settlement	$200
· Trial	$750
· Plus Trial Supplement*	$10,000
Civil Litigation Defense (Excludes defense of matters arising from divorce or post-decree actions)	
· Negotiation and Settlement	$350
· Trial	$1,500
· Plus Trial Supplement*	$10,000
DOCUMENT PREPARATION	
· Affidavits	$75
· Deeds	$60
· Document Review	$50
· Mortgages/Deeds of Trusts	$50
· Notes	$60

CASE TYPE	The Plan will Pay Up to a Maximum of:
FAMILY LAW	
Name change	$250
Uncontested Adoption	$400
Uncontested Guardianship/Conservatorship	$300
REAL ESTATE MATTERS	
Eviction and Tenant Problems (Tenant only)	
· Correspondence and Negotiations	$100
· Eviction Trial Defense	$275
· Plus Trial Supplement*	$10,000
Sale and/or Purchase of Primary Residence Only (Applies only to attorney who represents the Plan member, not the attorney representing the lending institution)	$425
TRAFFIC AND CRIMINAL MATTERS	
Juvenile Court Defense	
· Negotiation and Settlement	$300
· Trial	$600
· Plus Trial Supplement*	$10,000
Driving Privileges/Restoration of Suspended License	$250
Traffic Ticket Defense (No DUI)	
· Negotiated Plea	$150
· Trial	$180
· Plus Trial Supplement*	$10,000
WILLS AND ESTATE PLANNING	
Living Wills	
· Individual	$35
· Member and Spouse	$50
Powers of Attorney	
· Individual	$65
· Member and Spouse	$75
Wills and Codicils	
· Individual	$135
· Member and Spouse	$160
* Trial Supplement – In addition to fees indicated for trials, the Plan will pay one half of the attorney's hourly rate for representation in trial beyond the second day of trial for a maximum of $800 per day up to $10,000 total trial supplement maximum.	

Exclusions

Certain matters are excluded from coverage under the Legal Plan. No services, not even a consultation, can be provided for the following matters:

- payment made to a third party such as costs, witness fees, filing fees or fines
- appeals or class actions
- business, farm, patent or copyright matters
- matters for which you are or have been receiving legal services before you received an Authorization Number
- matters or disputes involving Montefiore, Hyatt Legal Plans, MetLife or a Plan Attorney
- matters concerning employment including Montefiore and statutory benefits
- divorce
- the settlement of estates.

Other Important Information

When Coverage Ends

Coverage stops for you and your family members if you cease to be an eligible associate, you discontinue your contributions or the Plan itself is terminated. Coverage for your family members also stops when they no longer meet the age and dependency requirements.

If you cease to be eligible to participate in the Plan or your employment with Montefiore ends, the Plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. New matters may not be started after you become ineligible.

If You Go on a Leave of Absence or Sabbatical

If you go on an approved leave of absence – or if you are eligible for and take an approved sabbatical – Group Legal Services coverage will continue if:

- you continue to have the required contributions deducted from your pay while you are on leave or sabbatical

  or

- you prepay the required contributions.

ERISA ADDITIONAL INFORMATION

This section contains information about how the plans are administered and your rights as a participant as defined under the Employee Retirement Income Security Act of 1974 (ERISA). Under the provisions of ERISA, the U.S. Department of Labor requires that Montefiore provide you with this additional information.

This Summary Plan Description (SPD) is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). If there are any discrepancies between the information contained in this SPD and the official written Plan documents, the Plan documents will govern.

What the ERISA Section Includes

Plan Name

The formal name of the Montefiore Associate Benefits Program is the Montefiore Medical Center Employee Health & Welfare Benefit Plan.

Plan Sponsor

The sponsor of the Plan and its component benefits is:

Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490

Plan Administrator

The Plan Administrator for all of the Plans is:

Vice President, Human Resources
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490
914.349.8531

Employer Identification Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service (IRS) to Montefiore Medical Center is 13-1740114.

Claim Denials and Appeals

You must file a claim to receive benefits from the plans. A claim for benefits should be submitted to and will be approved or denied by the appropriate fiduciary, Claims Administrator, insurance company or Plan Administrator, as designated in each plan.

The claims review fiduciary has the discretionary authority to interpret the coverages and the insurance policy (if any) and Plan document, and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties. The fiduciary for each benefit under the Plan is shown in the following table.

For These Covered Expenses	Claim Denials Are Received From And Appeals Should Be Directed To The Appropriate Fiduciary
MonteCare EPO MonteCare PPO	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 866.236.6748
Employee Assistance Program (EAP)	HealthCare EAP ESI/Longview Associates 800.666.5EAP www.myHealthCareEAP.com
Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 800.631.7780
UnitedHealthcare Vision	UnitedHealthcare Vision Claims Department PO Box 30549 Salt Lake City, UT 84130-0549 866.877.6187
Preventive & Diagnostic Dental Care Cigna DPPO Cigna Enhanced DPPO Cigna Dental Health Maintenance Organization (DHMO)	Cigna Healthcare P.O. Box 188037 Chattanooga, TN 37422-8037 800.Cigna24 (800.244.6224)
Flexible Spending Accounts	WageWorks PO Box 14053 Lexington, KY 40511 877.924.3967
Basic, Supplemental and Dependent Life Insurance Basic, Supplemental and Dependent Accidental Death & Dismemberment (AD&D) Insurance	Securian Financial Group, Inc. Group Insurance 400 Robert Street North St. Paul, MN 55101-2098 888.658.0193
Business Travel Accident (BTA) Insurance	Gerber Life Insurance Company c/o A.C. Newman & Company, 7060 North Marks Avenue, Suite 108, Fresno, CA 93711-0269 559.252.2525
Group Legal Services	Hyatt Legal Plans, Inc. Eaton Center, 111 Superior Avenue Cleveland, OH 44114-3292 800.821.6400

If Your Claim Is Denied

If your claim for benefits is denied, in whole or in part, you will receive a written notice. This notice will include the following:

1. the specific reasons for the denial of your claim
2. the specific references in the Plan document that support those reasons
3. a description of the information you must provide to perfect your claim and the reasons why that information is necessary
4. a discussion of the procedure available for further review of your claim, including your right to file a civil action following an adverse benefit determination on review
5. if the denial relies on an internal rule, protocol or guideline, such rule, protocol or guideline, or a statement that it will be provided free of charge to you upon request
6. if the denial is based on a medical necessity or an experimental treatment, an explanation of the clinical or scientific reasoning for denial of the claim, or a statement that it will be provided to you free of charge upon request.

In the case of a denial of an urgent care claim, the notice also will set forth a description of the expedited review process for an urgent care claim.

For medical and pharmacy claims, a notice of denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount (if applicable); and upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with the denied claim or appeal;
- The denial code and its meaning;
- A description of the Plan's standard for denying the claim;
- Information regarding any available internal and external appeals, including how to initiate an appeal;
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

Your Right To Appeal

You have the right to appeal a denial of your claim. You must submit a written appeal to the insurance company within 60 days after you receive the claim denial notice for life and accidental death & dismemberment insurance, business travel accident insurance, and the dependent care flexible spending account, and 180 days after you receive the claim denial notice for medical, dental, vision, health care flexible spending account, STD and LTD benefits. In preparing your appeal, you shall be entitled to request and receive, free of charge, copies of any documents, records or other pertinent information associated with your claim. This pertinent information includes any information in the initial benefit determination that was considered or generated (even if not relied on) and the identity of any medical expert who was consulted (even if not relied on). Any of this information may be submitted for determination, even if it was not considered in the initial benefit determination.

The claims review fiduciary will conduct a full and fair review of your appeal and it will not give deference to the initial benefit determination. The appeal shall be heard by an appropriate individual (or individuals), who is not the person having made the initial benefit determination or a subordinate of that person. This reviewer on appeal also may consult with a medical professional, who was not consulted or a subordinate of any person consulted in the initial benefit determination.

If your appeal involves an urgent care claim, the claims review fiduciary shall notify you of the decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your appeal. You may request an expedited appeal, which may be made either orally or in writing and allows all necessary communication between you and the administrator to take place via telephone, facsimile or other equally expeditious method.

If your appeal involves a pre-service medical, dental or vision claim or a pre-paid legal claim, the claims review fiduciary will notify you of the decision within 30 days after receipt of your appeal.

If your appeal involves a post-service medical, dental, vision, EAP or health care flexible spending account claim, the claims review fiduciary will notify you of the decision within 60 days after receipt of your appeal.

If your appeal involves an STD or LTD claim, the claims review fiduciary will notify you of the decision within 45 days after receipt of your appeal. An additional 45 days are permitted if special circumstances require extension. The period will be tolled until you respond to any information request from the plan.

If your appeal involves a life or accidental death & dismemberment insurance, business travel accident insurance claim, the claims review fiduciary will notify you of the decision within 60 days after receipt of your appeal. An additional 60 days are permitted if special circumstances require extension.

If your appeal is denied, in whole or in part, the claims review fiduciary will provide you with a notice with the following:

1. the specific reasons for the denial including the specific Plan provisions on which the denial relies
2. a statement informing you of the availability of any documents, records or other relevant information free of charge upon request
3. a description of any internal rule or protocol relied upon or a statement that any such rule or protocol will be provided free of charge upon request
4. an explanation of any voluntary appeals procedures that may be available and a statement of your right to bring a civil action
5. if the denial of an appeal is based on a medical necessity or experimental treatment, an explanation of the scientific or clinical judgment exercised or a statement that the explanation will be provided free of charge and upon request
6. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what might be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

For medical and pharmacy claims, a notice of denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount (if applicable); and upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with the denied appeal;
- The denial code and its meaning;
- A description of the Plan's standard for denying the claim;
- Information regarding any available internal and external appeals, including how to initiate an appeal;
- The availability of any contact information for an applicable office or health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

Throughout the claims review procedure, you may have a personal representative act on your behalf.

Any failure on your part to comply with the request for information by the Plan Administrator or insurance company may result in delay or a denial of your claim.

The insurance company has the authority to make final decisions with respect to paying claims under the Plan.

If you believe that you have been improperly denied a benefit from the Plan after making full use of the claims and appeals procedure, you may serve legal process on the Plan Administrator. No action shall be brought against the Plan in any court unless the claims and appeals procedures described above have been fully exhausted. A participant, beneficiary or claimant (each, a "claimant") asserting any action under Section 502 of ERISA or any other provision of ERISA shall do so, if at all, within one year from the date of denial of the claimant's last required appeal (or voluntary appeal, if offered and the claimant files a voluntary appeal). Any other claim or action (such as a claim or action relating to an alleged interference or violation of ERISA-protected rights) must be brought within one year of the date the claimant has actual or constructive knowledge of the acts or failures to act that are alleged to give rise to the claim or action. If the claimant does not bring such action within such period, he or she will be barred from bringing an action in court under ERISA related to such claim. All actions or litigation arising out of or relating to the Plan shall be commenced and prosecuted in the federal district court whose jurisdiction includes Bronx County, NY.

Legal Service

Legal process for all of the plans may be served on the Plan Administrator, care of the Senior Vice President & Chief Human Resources Officer, Montefiore Medical Center, 111 East 210th Street, Bronx, New York 10467-2490 and, in addition, on the claims review fiduciary.

Union Agreement

The benefits described in this SPD are provided in conjunction with a collective bargaining agreement between Montefiore and the following unions representing:

- Physical Therapists
  New York Chapter of the American Physical Therapy Association
  c/o Jack Ahern
  167 Main Street
  Northport, New York 11768
- The Albert Einstein Hospital Physical Therapists Association
  c/o Department of Rehabilitation Medicine
  1825 Eastchester Road
  Bronx, NY 10461

Copies of these collective bargaining agreements are distributed or made available to associates covered by the agreement and to any other associate or retiree who submits a written request for a copy to the applicable union or to the Vice President, Human Resources, Montefiore.

Administrative Information

Official Plan Name	Plan Number	Claims Administrator/Insurance Company	Plan Funding
Montefiore Medical Center Employee Health & Welfare Benefit Plan (the "Plan")	501	*MonteCare EPO/MonteCare PPO:* Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 866.236.6748	Associate and Montefiore contributions
		HealthCare EAP: ESI/Longview Associates 800.666.5EAP www.myHealthCareEAP.com	Montefiore contributions
		Cigna Preventive & Diagnostic/Cigna DPPO, Cigna Enhanced DPPO, Cigna DHMO: Cigna Healthcare P.O. Box 188037 Chattanooga, TN 37422-8037 800.Cigna24 (800.244.6224)	Associate and Montefiore contributions
		Prescription Drug: Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 800.631.7780	Associate and Montefiore contributions
		Life and AD&D Insurance: Securian Financial Group, Inc. Group Insurance 400 Robert Street North St. Paul, MN 55101-2098 888.658.0193	Associate and Montefiore contributions
		Business Travel Accident Insurance: Gerber Life Insurance Company c/o A.C. Newman & Company, 7060 North Marks Avenue, Suite 108, Fresno, CA 93711-0269 559.252.2525	Montefiore contributions
		Healthcare Flexible Spending Accounts: WageWorks PO Box 14053 Lexington, KY 40511 877.924.3967	Associate contributions
		Group Legal Services: Hyatt Legal Plans, Inc. Eaton Center 111 Superior Avenue Cleveland, OH 44114-3292 800.821.6400	Associate contributions
		Vision: UnitedHealthcare Vision PO Box 30978 Salt Lake City, UT 84130 800.638.3120	Associate contributions
	N/A	*Dependent Care Flexible Spending Accounts:* WageWorks PO Box 14053 Lexington, KY 40511 877.924.3967	Associate contributions

Plan Type and Plan Year

The following table shows the Plan year on which Plan records are maintained and the Plan type.

	Plan Type	Plan Year
Medical	Welfare providing healthcare benefits	January 1 to December 31
Employee Assistance Plan	Welfare providing employee assistance benefits	January 1 to December 31
Vision	Welfare providing vision care benefits	January 1 to December 31
Dental	Welfare providing dental benefits	January 1 to December 31
Prescription Drug	Welfare providing prescription drug benefits	January 1 to December 31
Flexible Spending Accounts	Welfare providing tax-free reimbursement of eligible health and dependent care expenses	January 1 to December 31
Life and AD&D Insurance	Welfare providing life and accidental death and dismemberment benefits	January 1 to December 31
BTA Insurance	Welfare providing business travel life and accident benefits	January 1 to December 31
Group Legal Services	Welfare providing legal benefits	January 1 to December 31

Plan Documents

This Summary Plan Description describes only the highlights of the plans that make up the Montefiore Medical Center Employee Health & Welfare Benefit Plan and does not attempt to cover all details. These are contained in the Plan documents and/or insurance company contracts, which legally govern the Plan and which are controlling in the event of a conflict with this Summary Plan Description. These documents, as well as the annual report of the Plan's operation and description (which are filed with the U.S. Department of Labor) are available for review through Montefiore's HR-Benefits Office during normal working hours. Upon written request to the Plan Administrator, copies of any of these documents will be furnished to a Program member or beneficiary within 30 days at a nominal cost.

Plan Continuation

Montefiore expects and intends to continue the Medical, Vision, Dental, Flexible Spending Accounts, Life and Accidental Death & Dismemberment Insurance, Business Travel Accident Insurance, and Group Legal Services Plans indefinitely, but reserves the right to amend, modify or suspend the Montefiore Medical Center Employee Health & Welfare Benefit Plan or any component benefit thereunder, in whole or in part, at any time and for any reason by action of its Senior Vice President & Chief Human Resources Officer, or his or her delegate. Further, the Finance Committee of the Board of Directors of Montefiore has the right (subject to the terms of any applicable collective bargaining agreement) to terminate the Montefiore Medical Center Employee Health & Welfare Benefit Plan or any component benefit thereunder. If Medical, Vision and/or Dental benefits are terminated, you will not have the right to any benefits or have any further rights – other than the payment of covered expenses you had incurred before the coverage terminated.

YOUR RIGHTS UNDER ERISA (EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974)

The benefits provided by the Montefiore Associate Benefits Program are covered by ERISA. The law does not require Montefiore to provide benefits. However, it does set standards for any benefits Montefiore offers – and it requires that you be given an opportunity to learn what those benefits are and your rights to them under the law. ERISA provides that all Plan participants, with appropriate notice, shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plans, including the Trust agreement and administrative service contracts, Plan descriptions 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 Employee Benefits Security Administration (EBSA) – formerly the Pension and Welfare Benefits Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plans, including the Trust agreement and administrative service contracts, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of each 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 healthcare 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.

HIPAA also requires that you be provided with a certificate of creditable coverage free of charge if you leave Montefiore. You can request a certificate of creditable coverage:

- when you lose health coverage
- when you become entitled to elect COBRA continuation coverage
- when your COBRA continuation coverage ends
- at any time before losing healthcare coverage

  or

- up to 24 months after losing healthcare coverage.

You can use a certificate of creditable coverage to eliminate or reduce any pre-existing condition limitation period under another group healthcare plan.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your Plans, called “fiduciaries” of the Plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. Although these rights are in no way a guarantee or contract of employment, no one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from a plan or exercising your rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the appropriate fiduciary review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the appropriate fiduciary 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 appropriate fiduciary 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 appropriate fiduciary.

If you have a claim for benefits that 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 a medical child support order or the status of a qualified domestic relations order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse a 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 pays 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 if, for example, it finds your claim is frivolous.

If you have any questions about these plans, you should contact the appropriate fiduciary. 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 EBSA, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 EBSA at **800.998.7542**.