# REGISTERED NURSES (NYSNA) BENEFITS PROGRAM
# 2017 SUMMARY PLAN DESCRIPTION

Montefiore

# Introduction

As a registered nurse of Montefiore, you enjoy the advantages of an excellent benefit program. The Registered Nurses Benefits Program is made up of a broad range of coverages that offer both flexibility and solid financial protection for you and your enrolled family members.

This is a Summary Plan Description (SPD) of the plans that make up your Montefiore Registered Nurses 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 including changes which have been collectively bargained between Montefiore and the New York State Nurses Association (NYSNA) which became effective January 1, 2011. 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.

We suggest you read this SPD carefully, share it with your family and keep it in a safe place for future reference. If you have any questions about your benefits, contact Montefiore's HR-Benefits Office.

This SPD supersedes all earlier SPDs for the Registered Nurses 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 Registered Nurses Benefits Program – and how the Program works – can be found in the following sections.

Page

Information regarding the following plans is available through these links:

- **Accidental Death & Dismemberment Insurance Certificate**
- **Business Travel Accident (BTA) Insurance**
- Disability
  - STD – **Registered Nurses**
  - LTD (**LTD Certificate Rider**) – **Registered Nurses**
- **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 63 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 48 for more details.

# Eligibility and Enrollment

The Registered Nurses 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.

***Claims Administrator*** – The company contracted by Montefiore to supervise the processing of claims and administration of the Montefiore Registered Nurses 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 and dental benefits, "Family Member" includes an enrolled RN's domestic partner if his or her domestic partner was enrolled in such benefits on April 26, 2013 and for whom coverage under the Registered Nurses Benefits Program has not ended. No domestic partners may be enrolled in the Registered Nurses Benefits Program after April 26, 2013.

***Full-time Registered Nurse*** – An RN who is regularly scheduled to work 100% of a full-time schedule and whose position is covered by a collective bargaining agreement between Montefiore and the New York State Nurses Association, if that agreement provides for the coverage described in this Summary Plan Description.

***Montefiore's HR-Benefits Office*** – Contact the HR-Benefits Office when you need assistance with benefits-related issues, 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 Registered Nurse*** – An RN who is regularly scheduled to work less than 100% of a full-time schedule whose position is covered by a collective bargaining agreement between Montefiore and the New York State Nurses Association if that agreement provides for the coverage described in this Summary Plan Description. A regular part-time RN does not include a contingent or per diem RN. However, to be eligible for the benefits described in this SPD, a part-time RN 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 law or common law in your state of residence.

***Temporary Registered Nurse*** – A full-time or part-time RN who is hired and scheduled to work for a definite period of limited duration that does not exceed six months.

## Eligibility for Registered Nurse Benefits

You are eligible to enroll in the Registered Nurses Benefits Program if you are employed by Montefiore in an eligible position covered by a collective bargaining agreement with the NYSNA and are a:

- Regular or temporary full-time registered nurse

  *or*

- Regular or temporary part-time registered nurse working at least 50% of a full-time schedule.

Eligible individuals include associates whose collective bargaining agreement provides for coverage under the Registered Nurses Benefits Program.

The following associates are *not* eligible for the Registered Nurses Benefits Program:

- Registered nurses whose position is covered by a collective bargaining agreement with 1199
- Associates whose position is covered by the Associates Benefit Program
- 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 Registered Nurses Benefits Program.

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 and dental benefits, "Family Member" includes an enrolled RN's domestic partner if his or her domestic partner was enrolled in such benefits on April 26, 2013 and for whom coverage under the Registered Nurses Benefits Program has not ended. No domestic partners may be enrolled in the Registered Nurses 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 Registered Nurses 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.

| Benefit area | If you are a full-time registered nurse | If you are a part-time registered nurse |
|---|---|---|
| Medical<br>· Registered Nurses Health Plan<br>Dental<br>· Registered Nurses Dental Benefits<br>· Dental Health Maintenance Organization (DHMO) | Montefiore pays the full cost; you contribute nothing. | You and Montefiore share the cost of coverage. Your share of the cost is pro-rated based on your schedule as compared to a full-time schedule and the number of hours worked. |
| Flexible Spending Accounts | You make all the contributions necessary to fund these accounts. | |
| Life Insurance | | |
| Basic Non-contributory Life Insurance | Montefiore pays the full cost; you contribute nothing. | |
| Additional Contributory Life Insurance | You pay the full cost of any Additional *Contributory Life Insurance* coverage you elect. Your cost depends on the amount of coverage you choose and your age. Current contribution rates are available from Montefiore's HR-Benefits Office. | |
| Accidental Death & Dismemberment (AD&D) Insurance | Montefiore pays the full cost of your AD&D coverage. | |
| Business Travel Accident (BTA) Insurance | Montefiore pays the entire cost of BTA coverage. You pay nothing. | |
| Disability Benefits | Montefiore pays the full cost of your STD and LTD benefits.<br>You make contributions for New York State disability benefits – .5% of your pay up to a maximum contribution of $1.20 each biweekly pay period – Montefiore pays the rest. | |

## Making Your Contributions

Any contributions are deducted from your bi-weekly paycheck.

Contributions you make for Medical and/or Dental (if any) and Flexible Spending Accounts are made with *before-tax dollars*.

*Before-tax dollars* come out of your earnings 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 or Dental coverage for a qualified domestic partner, the difference between the cost for single and family coverage will be included in your taxable earnings to calculate withholding taxes. 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.

Contributions for any Additional Contributory Life Insurance coverage you elect are made with after-tax dollars. After-tax dollars come out of your base earnings *after* all applicable taxes have been determined and withheld.

## 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***, contact the HR-Benefits Office at **914.349.8531** or at **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.**
  - 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 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 registered nurse and do ***not*** enroll within 30 days after you become eligible, you will default to the following coverages and not be able to make any changes during the year, unless you have a qualified change in status:

- Registered Nurses Health Plan – medical coverage for yourself only
- Registered Nurses Dental Benefits – dental coverage for yourself only
- Basic Non-contributory Life Insurance
- Accidental Death &Dismemberment (AD&D) Insurance
- Business Travel Accident and Long-term Disability Insurance
- No Additional Contributory Life Insurance – To elect Additional Contributory Life Insurance in the future, you will have to provide evidence of insurability, and that additional coverage will not go into effect until you receive written notification from the insurance company that your application has been approved.
- No Flexible Spending Accounts.

## HIPAA Special Enrollment Rights

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)
  - 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 eligible and are a: | |
|---|---|---|
| | **A regular full-time or eligible part-time RN** | **A temporary full-time or eligible part-time RN** |
| Medical, Flexible Spending Accounts | The first day of the month coincident with or after your first day of employment provided you have enrolled** | The first day of the month coincident with or after you complete three consecutive months of employment provided you have enrolled** |
| Dental | The first day of the month coincident with or after you complete three consecutive months of employment provided you have enrolled | The first day of the month coincident with or after you complete six consecutive months of employment provided you have enrolled |
| Life and Accidental Death & Dismemberment (AD&D) Insurance | The first day of the month coincident with or after your date of employment for Basic Non-contributory Life and AD&D Insurance<br>Additional Contributory Life Insurance, provided you have enrolled within 30 days of the date you first become eligible for benefits | The first day of the month coincident with or after you complete three months of employment for:<br>• Basic Non-contributory Life and AD&D Insurance<br>• Additional Contributory Life Insurance, provided you have enrolled within 30 days of the date you first become eligible for benefits |
| Business Travel Accident (BTA) Insurance | Your first day of employment | |
| Disability Benefits | | |
| • Paid Sick Leave | The day after you complete 30 days of employment | The day after you complete 90 days of employment |
| • New York State Disability Benefits | The day after you complete four weeks of employment | |
| • Supplementary Sick Pay<br>• Long-term Disability | The day after you complete 90 days of employment | |

* If you are absent from work on the day your coverage would otherwise begin, coverage will start the day after you return to Montefiore, perform the usual duties of your job and work your regularly scheduled hours.

**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 January 1st 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 date coverage would otherwise begin, coverage will be delayed 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

In certain cases, as shown in the following table, Internal Revenue Service (IRS) rules restrict your ability to change your Registered Nurses Benefits Program enrollment decisions at any time other than during the fall annual election period, unless you experience a qualified change in status.

| If you are an eligible | IRS change restrictions apply to |
|---|---|
| Full-time registered nurse | Flexible Spending Accounts |
| Part-time registered nurse | Medical, Dental and Flexible Spending Accounts |

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 or them ineligible for coverage
- You or your dependent lose coverage under any group health coverage sponsored by a governmental or educational institution.
- Change in your unmarried, under age 25 child's status to dependent full-time student
- Change from a non-participating part-time to a full-time Montefiore RN
- Change from a full-time to an eligible part-time Montefiore RN
- Geographic relocation that changes your DHMO membership options
- Strike or lockout involving you, your spouse, qualified domestic partner or dependent

  *or*

- 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 you dependent to change elections due to the reasons described above.

If you experience a qualified change in status, and IRS change restrictions apply, you can modify your 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 annual enrollment to modify your coverage and/or to add newly eligible family members
- You furnish appropriate documentation – i.e., a copy of 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 on the date of the status change. However, changes in your Life Insurance coverage which require approval by the insurance company will not become effective until you receive written notification from the insurance company that your application has been approved. Payroll adjustments will be reflected in the first paycheck you receive after Montefiore's HR-Benefits Office has been notified that the new coverage is effective.

## If Your Pay Is Stopped or Reduced

If your pay is reduced for any reason, your contributions (if any) will continue as long as you remain eligible 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.

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 RN whose schedule is reduced.

Your pay is stopped if you go on an unpaid leave of absence. Certain coverages can continue for a specified period of time as long as you contact Montefiore's HR-Benefits Office and prepay any required contributions.

## 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.

***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 Registered Nurses Health Benefits Plan for the premiums advanced by Montefiore on your behalf unless your termination of employment is for reasons beyond your control.)

***Military Leave*** – Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you can elect to continue healthcare coverage for the first six-months of a military leave, provided you continue to make any required contributions. If you remain absent from work 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 Medical Leave*** – If you become disabled and are unable to work, healthcare coverage for you and your family members continues for six months, provided you continue to make any required contributions. After six months, coverage for your family members stops, unless they elect COBRA continuation coverage. Your healthcare coverage continues during the period you apply for Long Term Disability and Social Security disability benefits. Your coverage stops when your LTD and Social Security benefits are either approved or denied, but will not continue for longer than 24 months from the date you first became disabled. After your healthcare coverage stops, you can elect COBRA continuation coverage.

***Education Leave*** – Healthcare coverage continues through the end of the month in which your education leave begins provided you continue to make any required contributions. If you remain absent from work for more than one month, you 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.

***New York State Nurses Association Business Leave*** – Your healthcare coverage continues for the first month of an approved leave for NYSNA business, provided you continue to make any required contributions. If you remain absent from work for more than one month, you can elect COBRA continuation coverage.

## 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
- Have the contributions deducted on a before-tax basis from any supplementary sick pay

  *or*

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

# Healthcare

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

**What the Healthcare Section Includes**

# Montefiore Medical Benefits for Registered Nurses

Your medical benefits pay for a variety of medical services and supplies in and out of the hospital. As an eligible registered nurse, you can choose Montefiore's Registered Nurses Health Plan, or you can elect no coverage.

This section of your Summary Plan Description describes the benefits provided under the Registered Nurses Health Plan.

Your medical coverage provides 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 benefits, 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.

***Coordination of Benefits (COB)*** – A provision of the Montefiore Health Benefits Plan for Registered Nurses that applies when you or a family member is entitled to benefits from this Plan and another group plan providing medical or dental benefits. Under this provision, the benefits payable from all plans combined are limited to 100% of the covered expense.

***Copayment*** – A flat-dollar amount you pay for certain medical services, such as prescription drugs at an authorized Express Scripts pharmacy.

***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, and 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 services are paid.

***Doctor (or physician)*** – An individual 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 (for Registered Nurses Health Plan participants)*** – 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 Registered Nurses Health Plan. Empire is not the Claims Administrator for dental benefits, prescription drug benefits, Flexible Spending Accounts or Life Insurance.

***Empire BlueCross BlueShield Indemnity Network*** – A national network of 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. For more information or if you would like to find a network provider you can contact Empire at **866.236.6748** or online at **www.empireblue.com/montefiore**.

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

- It is within the research or experimental/investigational stage
- 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
- It is not in general use by qualified physicians who are specialists in the field of the illness
- 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. Express Scripts – in conjunction with physicians and pharmacists – compiles the formulary list and evaluates the safety, effectiveness and affordability of the medications. They also update the list as the FDA approves new drugs.

***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 (FDA) 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 facility or 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 doctors 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.

***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

  *and*

- The most appropriate treatment that 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 Health Benefits Plan for Registered Nurses*** – Also referred to as the Registered Nurses Health Plan.

***Montefiore Medical Group*** – A division of Montefiore responsible for the operation of a network of 19 community-based primary care sites, and for the hospital-based primary care clinics; and it also operates a range of related primary care and outreach services.

***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

  *and*

- Conventional weight reduction measures have failed

  *and*

- The excess weight causes a medical condition – e.g., physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

***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.

***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 Providers*** – Physicians and other healthcare providers who are not part of the MIPA or Empire BlueCross BlueShield Indemnity Networks.

***Participating Pharmacy*** – A pharmacy that has contracted with Express Scripts to provide prescription services.

***Reasonable and Customary (R&C)*** – Reasonable and Customary charges are based on an HIAA survey of charges assessed for similar care within the geographic area in which the services are provided. Empire establishes its payment schedule for out-of-network claims based on the 70th percentile of these charges. The Plan benefit is then determined by applying the cost-sharing percentage (e.g. 70% or 80%) to this amount; you are responsible for paying the balance of the bill to the provider.

The Reasonable and Customary payment schedule does not apply to services provided by Montefiore Medical Group (MMG) primary care physicians, salaried Montefiore specialists, physicians in the Montefiore Integrated Provider Association (MIPA) and Empire BlueCross BlueShield Indemnity Network.

***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, 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 Registered Nurses 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 registered nurse 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.

***Substance Abuse Treatment Facility*** – A public or private facility, licensed and operated according to the law that 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.

## Registered Nurses Health Plan

The Registered Nurses Health Plan is designed to encourage you to make use of Montefiore providers and facilities. Of course, you're free to use any physician or facility you choose.

## RN Plan Montefiore Provider Network

This Network pays ***100%*** of the services and supplies provided by:

- ***Physicians and Therapists***:
  - A Montefiore Medical Group Primary Care Physician (PCP) at a Medical Group facility
  - A salaried Montefiore specialist at a Montefiore facility. (This Network does not include voluntary Montefiore Primary Care Physicians or voluntary Montefiore specialists.)
- ***Hospitals and Other Facilities*** – 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
- ***Laboratories*** – Quest Laboratories, LabCorp, Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital laboratories.

Check the Empire Website – **www.empireblue.com/montefiore/MMG Directory** – for a list of network providers.

## Preferred Provider Network

Montefiore has contracted with Empire for access to its Empire Indemnity Network of physicians, hospitals and other healthcare providers. You can visit any physician in any specialty without a referral.

Preferred providers agree to provide services at a discount, resulting in lower out-of-pocket costs to you. The discount applies to the cost of covered services provided. It does not affect the cost-sharing percentages for out-of-network care established by the Plan. For example, if you visit a physician who participates in the Empire Network, the Plan pays 80% and you are responsible for 20% of the discounted rate. You are not required to use these providers. However, you may save money if you do.

To find an Empire Indemnity Network provider, you can call the Empire customer service call center at **866.236.6748** or go to **www.empireblue.com/montefiore/Find A Doctor.**

## Provider Network Summary

| | RN Plan Montefiore Provider Network | Preferred Provider Network |
|---|---|---|
| Physicians and Therapists | · A Montefiore Medical PCP at a Medical Group facility<br>· A salaried Montefiore specialist at a Montefiore facility. | Empire Indemnity Network |
| Hospitals and Other Facilities, Skilled Nursing Facility, Hospice | 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 | Empire Indemnity Network |
| Laboratories | Quest Laboratories, LabCorp, Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital laboratories | Any hospital laboratory participating in the Empire Indemnity Network |

## The Deductible

The *deductible* is the dollar amount that you must pay *before* the Registered Nurses Health Plan starts paying for certain expenses. The deductible is $50 and applies to each 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 following features help limit the deductibles you and your family members must pay:

- Expenses incurred during the last three months of the year that are used to satisfy the deductible, can also be used to satisfy the next year's deductible.
- Once three family members each meet their individual deductibles in a calendar year, no additional deductibles need be met by any other family members.

## 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 (up to R&C limits) including coinsurance, deductibles and copayments in any calendar year.

| **Out-of-pocket Maximum** | **Individual** | **Family** |
|---|---|---|
| Registered Nurses Health Plan<br>(including Deductible + Copayments + Coinsurance) | $5,600 | $11,200 |
| Express Scripts | | |
| • Prescription Drug – Copayments + Coinsurance<br>Note: Does not include the difference between the cost of generic and brand name drugs when a generic equivalent is available | $1,250 | $2,500 |

Once a family member's share of eligible expenses reaches the out-of-pocket maximum, the Registered Nurses Health Plan pays 100% of that family member's eligible covered medical expenses for the rest of that 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

### In-hospital Care

The Registered Nurses Health Plan pays 100% – with no deductible – for semi-private hospital room and board and medical supplies for up to 365 days. If only private rooms are available, the RN Health Plan covers 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 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 RN Health Plan provides benefits for inpatient psychiatric care and substance abuse – in either a general hospital or special treatment facility (psychiatric hospital).

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).

# Registered Nurses Health Plan Benefit Summary

## Here is a brief overview of the RN Health Plan.

| Inpatient Medical/Surgical Services | Registered Nurses Health Plan Your Cost If You Use: | | |
|---|---|---|---|
| | **RN Montefiore Provider Network** | **Empire Indemnity Network** | **Out-of-network** |
| **Hospital Inpatient Services and Ancillaries** – semi-private room and board for up to 365 days<br>• Accidental Injury<br>• General Illness<br>• Inpatient Surgery<br>• Maternity<br>• Medical Rehabilitation<br>• Medical Supplies<br>• Mental Healthcare<br>• Organ Transplant<br>• Prosthetics and Orthotics<br>• Substance Abuse<br>• Well/Sick Newborn Care | $0 | $0 | $0 |
| **Emergency Room Care** | | | |
| • Bona Fide Emergency | $0 | $0 | $0 |
| • Other than a Bona Fide Emergency | $0 | $0 | $0 |
| • Urgent Care Facility | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Home Healthcare** – up to a maximum of 100 visits each 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.<br>Covered services must be provided by a certified home health agency and include:<br>• Ambulance or ambulette to the hospital for needed care<br>• Home infusion therapy<br>• Medical social worker visits<br>• Medical supplies, drugs and medicines prescribed by a physician<br>• Necessary laboratory services<br>• Part-time home health aide services<br>• Part-time professional nursing<br>• Physical, occupational or speech therapy<br>• X-ray and EKG services. | $0 | $0 | $0 |
| **Hospice** – for the medical care and treatment of a terminally ill patient for up to 210 days – provided the care is not primarily custodial. | $0 | $0 | $0 |
| **Skilled Nursing Facility** – within 14 days after a hospital stay | $0 | $0 | $0 |
| **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 | 20%[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 330% 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.

| Inpatient Medical/Surgical Services | Registered Nurses Health Plan Your Cost If You Use: | | |
|---|---|---|---|
| | RN Montefiore Provider Network | Empire Indemnity Network | Out-of-network |
| **Advanced Reproductive Technologies** – up to a maximum lifetime benefit of $5,000; for treatment (hospital, surgical, medical and prescription drugs) related to infertility including:<br>• artificial insemination<br>• in-vitro fertilization /ZIFT/GIFT/ICSI | $0 | $0 up to $2,000, 20%[1] coinsurance after deductible thereafter | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |
| **Allergy Care** – Office Visits, Testing, Treatment | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **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 |
| Ambulatory Surgical Facility | $0 | $0 | $0 |
| **Anesthesia Services** – if performed by a licensed anesthesiologist in connection with a surgical procedure | $0 | $0 | $0 |
| **Assistant Surgeons' Fees** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Birth Control** – IUDs, diaphragm fittings, Norplant | $0 | $0 | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |
| **Birthing Center** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Blood, Blood Plasma or Blood Derivatives** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Cardiac Rehabilitation** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Chemotherapy** –non-cancer and cancer | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Chiropractic Services** (limited to $1,000 in a calendar year) | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance |
| **Consultations** | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Dental Services**<br>• extractions of impacted wisdom teeth and other teeth impacted in bone which require oral surgery<br>• treatment of an injury to sound natural teeth within 12 months of the date of injury | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Diagnostic X-rays** – including MRI, MRA, PET, CAT scans, Nuclear Cardiology | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Durable Medical Equipment** – purchase and rentals | N/A | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Foot Care** – routine care for up to 8 visits in a calendar year, including removal of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Genetic Testing** (physician must certify that it is medically necessary) | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Hearing Care** – exams, hearing aids (including repairs and batteries) | N/A | $0 | $0 |
| **Hemodialysis** | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Immunizations** – Hepatitis A, annual flu shot, tetanus, Pneumococcal | $0 | 20%[1] coinsurance after deductible | 20%[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 330% 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.

| Inpatient Medical/Surgical Services | Registered Nurses Health Plan Your Cost If You Use: | | |
|---|---|---|---|
| | RN Montefiore Provider Network | Empire Indemnity Network | Out-of-network |
| **Injections/Biologicals** – including injections for Depo-Provera | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Laboratory Tests** | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Medical Supplies** | $0 when billed with other covered services i.e., chemotherapy, surgery | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Mental Healthcare**– outpatient facility and professional services | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Morbid Obesity** – surgical treatment (limited to one procedure in a lifetime) | $0 | $0 up to $2,000, 20%[1] coinsurance after deductible thereafter | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |
| **Nutrition Counseling** – up to six sessions each calendar year, if referred by a physician. In-network providers are Registered Dieticians in the Empire BlueCard PPO Network, including Montefiore Registered Dieticians. | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Obstetrical (Maternity) Care** – including:<br>• termination of pregnancy<br>• certified nurse-midwife | $0 | $0 up to $2,000, 20%[1] coinsurance after deductible thereafter | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |
| **Occupational, Respiratory and Speech Therapy** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Orthotics** | N/A | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Physical Therapy** | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Physicians' Visits** | | | |
| • In-hospital by your attending physician | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| • Office visits including emergency care/first aid and medical evaluations | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Polysomnograms** – for the treatment of sleep apnea, narcolepsy, insomnia, sleep walking, night terrors and bed wetting | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Pre-surgical/Pre-admission Tests** – if performed within 14 days of a scheduled hospital admission | $0 | $0 | $0 |
| **Preventive Care**<br>• Routine Physical Exam with PCP including OB/GYN<br>• Routine Child Exam/Immunizations<br>• Routine Mammography | $0 | $0 | You may be balance billed for amounts in excess of in-network reimbursement |
| **Prosthetics** – including lenses and/or glasses after cataract surgery, artificial limbs and eyes, wigs and toupees | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| Radiation Therapy | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Reconstructive Surgery Following a Mastectomy** including:<br>• reconstruction of the breast on which the mastectomy was performed<br>• surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses<br>• treatment of physical complications at all stages of the mastectomy, including lymphedemas | $0 | $0 up to $2,000, 20%[1] coinsurance after deductible thereafter | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |

[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 330% 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.

| Inpatient Medical/Surgical Services | Registered Nurses Health Plan Your Cost If You Use: | | |
|---|---|---|---|
| | RN Montefiore Provider Network | Empire Indemnity Network | Out-of-network |
| **Second Surgical Opinions** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Shock Therapy** | $0 | 20%[1] coinsurance | 20%[2] coinsurance |
| **Sleep Disorders** – treatment of sleep apnea and narcolepsy | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Sterilization** (but not reversals) | $0 | $0 up to $2,000, 20%[1] coinsurance after deductible thereafter | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |
| **Substance Abuse Treatment** | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Surgeons' Fees** | $0 | $0 up to $2,000, 20%[1] coinsurance after deductible thereafter | $0 up to $2,000, 20%[2] coinsurance after deductible thereafter |
| **Vision Therapy** (up to 30 visits each calendar year at MMC Clinic only) | $0 | 20%[1] coinsurance after deductible | 20%[2] coinsurance after deductible |
| **Well-Baby Care** – limited to 11 visits up to age 2 | $0 | $0 | 20%[2] coinsurance |
| **Well Woman Care**<br>• Screening for gestational diabetes<br>• HPV testing<br>• Contraceptive methods and counseling<br>• Breast feeding support, supplies and counseling<br>• Counseling for sexually transmitted infections<br>• Counseling and screening for HIV<br>• Screening and counseling for interpersonal and domestic violence | $0 | $0 | You may be balance billed for amounts in excess of in-network reimbursement |

[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 330% 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.

## Vision

### LASIK Surgery

Montefiore Laser and Eye Care Center at Montefiore Medical Specialists of Westchester offers LASIK Surgery discounts of ***20%*** off of the regular charge for you and your family members!

Charges in connection with LASIK surgery are also reimbursable expenses under a Healthcare Flexible Spending Account (FSA). A Healthcare FSA is funded through payroll deduction with pre-tax dollars. You pay ***no taxes*** when money is deposited into the account. You pay ***no taxes*** when you use your account to pay for eligible expenses. The combination of the discount that is being offered and the tax savings associated with paying for the surgery with pre-tax dollars through an FSA help make this surgery more affordable.

If you are interested in obtaining more information about LASIK surgery and the services offered at Montefiore's new facility, please contact **718.920.2020**; Montefiore Laser and Eye Care Center at Montefiore Medical Specialists of Westchester, 495 Central Park Avenue, Scarsdale, New York 10583

If you want to learn how to use your Healthcare FSA to help pay for the surgery, please contact HR Benefits at **914.349.8531** or through **montebenefits@montefiore.org**.

## Maximum Benefits

The Registered Nurses Health Plan provides unlimited lifetime medical 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
- Advanced reproductive technologies – up to a maximum lifetime benefit of $5,000
- Chiropractic services – up to $1,000 each calendar year
- Foot care – up to eight visits in a calendar year
- Home healthcare – up to 100 visits each calendar year
- Hospice care – up to 210 days
- Morbid obesity – limited to one surgical procedure in a lifetime
- Nutritional counseling – up to six counseling sessions in a calendar year
- Physical exams (routine) – once in a calendar year
- Vision therapy – up to 30 visits each calendar year only at MMC Clinic
- Well baby care – limited to 11 visits up to age 2.

## Exclusions

The Registered Nurses Health Plan does not pay 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 expenses
- Counseling – marital, family or sex counseling (unless provided by the Staff Counseling Service under the Employee Assistance Program)

- 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 pool, 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 in the Registered Nurses Health Plan 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 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
    - Not medically necessary for treatment of your condition
    - Provided primarily for research
    - Not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury
  - 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 the Registered Nurses Health Plan

  - 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 – including bruxism (grinding of teeth), drug dependency, dream anxiety attacks, shift work or schedule disturbances, migraine headaches (except as specified under covered services)
- Sterilization – procedures to reverse voluntary sterilization
- Surrogate expenses
- Telephone calls or medical advice provided by telecommunications
- TMJ – temporomandibular joint dysfunction – surgical and non-surgical treatment
- Travel or lodging expenses for a physician or a patient, except for emergency ambulance service
- Vaccinations, inoculations or immunizations, except as specified under covered services
- Vision benefits
- Vision perception training
- Vitamins, minerals and food supplements
- Weight reduction – treatment, instructions, activities or drugs for weight reduction or control, except as diagnosed condition of morbid obesity.

## Coordination of Benefits (COB)

The Montefiore Health Plan for Registered Nurses contains a coordination of benefits (COB) 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 100% of covered expenses subject to Plan maximums. Coordination of benefits also applies to Medicare, Champus/Tricare and any other government programs with which the Registered Nurses Health Plan is allowed to coordinate by law. The coordination 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 Registered Nurses Health Plan is not allowed to coordinate by law. Medicare follows different rules than those explained below – see "**Coordination with Medicare**".

Under the COB provision, the plan that has primary responsibility always pays first. Briefly, COB works like this.

- When the other plan does not have a COB provision, it is considered primary.
- When both plans have coordination of benefits provisions:
  - 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 is secondary and pays the remaining costs to the extent of coverage. This is called the "birthday" rule.
  - In those plans that do not include the "birthday" rule, the father's plan is primary and will pay children's benefits first. The mother's plan is secondary and pays the remaining costs to the extent of her coverage. 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 the primary plan.
  - If there is no decree, the plan which covers the child as a dependent of the parent with custody will be the primary plan; 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.

Claims should always be submitted to the primary plan first.

Under the COB provision, you and your eligible family members can receive up to 100% of covered medical charges from all plans combined – but no more than that.

## Coordination with an HMO

The Montefiore Health Plan for Registered Nurses also coordinates 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 Montefiore's Registered Nurses Health Plan

  *or*

- Your spouse (or qualified domestic partner) is covered by an HMO and is also enrolled as your dependent in Montefiore's Registered Nurses Health Plan.

In these instances, you may file a claim under the Registered Nurses Health Plan for expenses not covered by the HMO. If the claim is for a covered expense, the Plan will pay its regular benefit.

## Coordination with Medicare

The Montefiore Health Plan for Registered Nurses provides primary coverage for the following covered Medicare-eligible individuals:

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

If you are actively employed, 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's program. If you do not elect Medicare, you will continue to be covered under the Registered Nurses Health Plan.

## 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

If you elect the Registered Nurses Health Plan, you can obtain:

- Up to a 90-day supply of each prescribed Montefiore pharmacy formulary drug at Montefiore's outpatient pharmacies at no cost to you (all you need do is present your Empire identification card).
- Up to a 30-day supply of each prescription drug at an Express Scripts participating retail pharmacy – subject to copayments – upon presentation of your Empire identification card. Participating pharmacies include most major pharmacy chains. You can call Express Scripts at **800.631.7780** to verify whether a pharmacy is participating or to obtain the names of participating pharmacies in your area.

  If you purchase a prescription drug from a non-participating pharmacy, you will be required to pay for the prescription and submit a Prescription Drug Claim Form to be reimbursed. 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.
- Up to a 90-day supply of each prescription drug through the Home Delivery Pharmacy Service – subject to copayments. Remember that it takes approximately 14 days to receive your prescription – so make sure you keep an adequate supply of your medications on hand.

## Prescription Drug Out-of-pocket Maximum

Your share of expenses for prescriptions obtained from Express Scripts participating retail pharmacies, home delivery pharmacy service or out-of-network pharmacies is limited to $1,250 for any one covered person ($2,500 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.

If you purchase a brand name medication (preferred and non-preferred) 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 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.

## Benefit Summary

The following table shows the benefits Montefiore provides for prescription drugs.

| If I Use | Your Cost If You Use: | | |
|---|---|---|---|
| | **Generic** | **Preferred Brand Name** | **Non-preferred Brand Name** |
| **Montefiore Outpatient Pharmacies** – Montefiore Pharmacy Formulary Drugs (up to a 90-day supply of each prescription) | $0 | $0 | $0 |
| **Express Scripts** | . | . | . |
| · Participating Retail Pharmacy[2] (up to a 30-day supply of each prescription) | $7 copay | $10 copay | $20 copay |
| · Home Delivery Pharmacy Service (up to a 90-day supply of each prescription) | $7 copay | $10 copay | $20 copay |
| [1] 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 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.

Prior authorization insures that drugs are being used for their designed purpose. For specialty medication, Express Scripts will review your prescription to determine if it 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 a coverage review.

## 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*** – ensures that drugs are being used for their intended purpose. If you are taking any of the following classifications of drugs, 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 a***re taking drugs that r***equire 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 available in the "Medicare & You" Handbook. You'll get a copy of the Handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy 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<br>Bronx, NY 10467-2490 |
| Phone Number: | **914.349.8531** |

# Montefiore Dental Benefits for Registered Nurses

Your 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 Registered Nurses Dental Benefits and Cigna DHMO. Cigna is not the Claims Administrator for health benefits, prescription drug 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, or any other sources of dental payments 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 (COB)*** – 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 plans combined are limited to 100% of the covered expense.

***Deductible –*** The dollar amount you must pay each year for certain covered services before Registered Nurses Dental Benefits starts paying part of the costs.

***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) practicing within the scope of his or her license under the laws of the state or jurisdiction in which the services are provided.

***Montefiore Dental Benefits for Registered Nurses*** – Also referred to as Registered Nurses Dental Benefits.

***Subrogation*** – The right of the Montefiore Registered Nurses 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 registered nurse 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)
- Montefiore Dental Benefits for Registered Nurses

### 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 Registered Nurses Dental Benefits
- 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).

However, to get the most from the DHMO you must receive care from DHMO participating network dentists.

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.

### Montefiore Dental Benefits for Registered Nurses

Under Montefiore Dental Benefits for Registered Nurses, you may visit any licensed dentist or specialist without a referral. Once you meet the deductible, the plan pays a percentage of eligible dental expenses covered by the plan.

RN Dental Plan participants may access the Total Cigna Network, which includes the Montefiore Department of Dentistry. The Total Cigna Network offers two levels of potential savings from providers:

- Cigna DPPO Advantage Dentists may provide a better benefit level with greater savings
- Cigna DPPO Dentists may provide a lesser benefit level while still offering savings.

## Cigna Reimbursement Levels

### In-network Benefits

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* Montefiore Dental Benefits for Registered Nurses starts paying benefits for certain expenses. The deductible applies to each covered individual once each calendar year. The deductible amount is $25 for each individual under Montefiore Dental Benefits for Registered Nurses. Any amounts you pay toward *basic, major and orthodontic services* count toward satisfying the deductible.

## 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**
- **RN Dental Benefits Summary**

| Dental Services and Supplies | DHMO | RN Dental Benefits[1] |
|---|---|---|
| Preventive and Diagnostic Services, including:<br>· Oral Exams<br>· Cleanings<br>· Fluoride Application<br>· Sealants<br>· Space Maintainers (limited to non-orthodontic treatment)<br>· Routine X-Rays<br>· Non-Routine – X-Rays<br>· Emergency Care to Relieve Pain | $0 | 20% coinsurance after the $25 annual deductible |
| Basic Restorative Services, including:<br>· Composite Fillings<br>· Oral Surgery<br>· Surgical Extraction of Impacted Teeth<br>· Anesthetics<br>· Major & Minor Periodontics<br>· Root Canal Therapy/Endodontics<br>· Brush Biopsy<br>· Stainless Steel/Resin Crowns | 20% coinsurance | 20% coinsurance after the $25 annual deductible |
| Major Restorative Services, including:<br>· Crowns/Inlays/Onlays<br>· Dentures<br>· Bridges<br>· Relines, Rebases, and Adjustments<br>· Repairs – Bridges, Crowns, Dentures, and Inlays<br>· Prosthesis Over Implants | 50% coinsurance | 50% coinsurance after the $25 annual deductible |
| **Orthodontics Services**, including:<br>· Comprehensive orthodontic treatment<br>· Post treatment stabilization<br>· Interceptive orthodontic treatment<br>· Limited orthodontic treatment | 50% coinsurance | 20% coinsurance after the $25 annual deductible |
| **Lifetime Orthodontic maximum** | None | $1,500 |
| **Annual maximum benefits for each covered person** (Preventive and Diagnostic, Basic and Major Services combined) | None | $1,300 |

[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 (Registered Nurses Dental Benefits)

Pre-treatment review lets you know in advance how much Registered Nurses Dental Benefits 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 the 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 (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 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

You and each covered family member can receive up to $1,300 in annual dental benefits under Registered Nurses Dental Benefits for preventive and diagnostic, basic and major services combined. There is a separate individual lifetime maximum benefit of $1,500 for orthodontics.

If you elect the DHMO and obtain care from your network primary care dentist, there are generally no maximum benefit levels. However, frequency of treatment and/or age limitations may apply, as described in the list of covered dental services and supplies.

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 and Partials – 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

Your Dental options 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

Registered Nurses Dental Benefits 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 **Coordination 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 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 registered nurses 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 72 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 then 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 Montefiore's Registered Nurse 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 identify yourself as a registered nurse covered under Montefiore's Registered Nurses Health Plan and instruct them to send the invoice to the Claims Administrator.

## 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 your portion of the form in full. Have your physician or other healthcare provider complete his or her portion on the back of that form. Be sure that *all* questions are answered, even if the answer is “no” or “N/A” (does not apply).

Attach all necessary documentation to the form:

- A description of the services and supplies 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 the 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 covered expenses:** | **Claims should be submitted as follows:** |
|---|---|
| Medical | Empire BlueCross BlueShield<br>PO Box 1407, Church Street Station<br>New York, NY 10008-1407<br>**866.236.6748** |
| Dental, including:<br>· Montefiore Dental Benefits for Registered Nurses<br>· Cigna Dental Health Maintenance Organization (DHMO) | Cigna Healthcare<br>P.O. Box 188037<br>Chattanooga, TN 37422-8037<br>**800.Cigna24 (800.244.6224)** |
| Prescription Drugs | Express Scripts<br>100 Parsons Pond Drive<br>Franklin Lakes, NJ 07417-2603<br>**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 Registered Nurse 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 at the end of the month in which:

- The Registered Nurses Benefits Program is terminated
- You no longer meet the eligibility requirements as an active registered nurse
- 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, healthcare coverage ends:

- For your dependent children – at the end of the calendar year
- For your spouse or qualified domestic partner – at the end 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 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, 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 or 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 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 RN | · layoff, leave of absence (including military leave), or termination of employment (for reasons other than your gross misconduct)<br>· 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 RN | · your spouse or domestic partner is on layoff, leave of absence, or terminates employment (for reasons other than gross misconduct)<br>· a reduction in your spouse or domestic partner's regularly scheduled hours | 18 months |
| | · your spouse or 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 domestic partner<br>· your spouse or domestic partner is disabled<br>· divorce, legal separation, annulment or termination of a qualified domestic partnership | 36 months |
| a covered dependent child of an MMC RN | · your parent is on layoff, leave of absence or terminates employment (for reasons other than gross misconduct)<br>· 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<br>· your parents' divorce, legal separation, annulment or termination of a qualified domestic partnership<br>· 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.

## HIV Coverage

If you contract the HIV virus as a result of your employment with Montefiore and become eligible for Workers' Compensation benefits, medical coverage for you only will continue until you become eligible for Medicare, but not for more than 29 months. Coverage for eligible family members enrolled while you were actively employed at Montefiore can be continued by electing COBRA coverage. When Medical coverage for you stops, you can elect COBRA coverage for yourself if you are not then eligible for Medicare.

## 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 Rights** – 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 health care.

- A***ccess 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 that you not make this payment since the 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 that 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 Health Plan for Registered Nurses 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 paid 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 (QMCSOs)

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 Registered Nurses Benefits Program 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 RN 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 Registered Nurses and their family members who are covered by Montefiore's Registered Nurses Health Plan. All services are completely confidential and free.

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.

Your PHN will help you:

- Find a physician or other healthcare provider; schedule appointments and navigate other healthcare services
- Communicate with care providers and coordinate healthcare related services from multiple doctors and facilities
- Understand your medications. Your PHN may arrange a consultation with the Care Guidance Program's pharmacist to ensure that you are being treated with the most effective medication regimen.
- Prepare a Living Will, identify a Healthcare Proxy and discuss these important Life Planning decisions with family members and healthcare providers.

## Voluntary Pre-Notification

You are requested to voluntarily pre-notify 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

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 Flexible Spending Accounts, 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 Flexible Spending Accounts Section Includes**

## Glossary of Key Terms

***Annual Base Earnings*** – Your annual base rate of pay including any tax-deferred contributions you make to a qualified plan sponsored by Montefiore, for example, the Personal Voluntary Annuity (PVA) Plan, but excluding differentials, overtime pay, uniform allowances 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 listed in IRS Publication 503 as eligible for reimbursement and incurred 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 listed in IRS Publication 502 as eligible for reimbursement through Healthcare Flexible Spending Accounts.

***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 pay you for eligible dependent care expenses if that care is necessary so that you can work. If you are married, that care must be necessary so that both you and your spouse can work or look for work.

Only expenses incurred while you are making contributions to the Flexible Spending Accounts 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 |
| $3,000[3] | $979.50 | $1,069.50 | $1,219.50 |
| $4,000[3] | $1,306.00 | $1,426.00 | $1,626.00 |
| $5,000[3] | $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.

[3] The maximum you can contribute to the Health Care Account is $2,000.
You can contribute up to $5,000 to the Dependent Care Account.

## 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 $2,000.
- **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 your 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 Account.
- The Dependent Care Account operates on a calendar year basis. This means that eligible expenses you incur in one calendar year can only be paid with contributions you make in the same calendar year.
- If you are newly eligible or have a qualified change in status and enroll in a Healthcare or Dependent Care account during the year, only expenses incurred while you are making contributions to the Flexible Spending Accounts are eligible for reimbursement. You cannot obtain reimbursement for expenses incurred before your 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 Flexible Spending Accounts 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 eligible for reimbursement through flexible spending accounts as determined 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. 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
- 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
- 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)
- Nursing home confinement for treatment of illness or injury
- 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
- Transportation and travel expenses for medical care
- Vaccinations and immunizations
- Vasectomy
- 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 (for treatment of a medical condition) 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)
- Funeral and burial expenses
- Fees for exercise, athletic, health or fitness club dues, exercise equipment
- 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
- Over-the-counter medications without a doctor's prescription, vitamins, natural foods, dietary supplements or homeopathic medications to improve for 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 for general health improvement
- 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 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 beginning in 2003) 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 IRS Reporting Requirements

It is important to note that to use the tax credit or the Dependent Care Account, you must complete and file IRS Form 2441 with your individual federal income tax return 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 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. Canceled checks and other non-itemized receipts alone will not be accepted.
  - 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 the name, address and taxpayer identification number of your dependent care provider, the name of the eligible dependent, the date the services were rendered, the type of service(s) and the amount charged.

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 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 contributed prior to your death, less any amounts already paid to you.

# Short-term Disability(STD) Benefits

Under Short-term Disability (STD) you are considered disabled if, as the result of a non-occupational injury or sickness (including pregnancy), you are unable to perform your regular duties or any other duties that Montefiore may offer you at your regular wages.

STD benefits are provided by:

- Paid Sick Leave
- New York State Disability

  *and*

- Supplementary Sick Pay.

**What the STD Section Includes**

## Paid Sick Leave

If you are unable to work due to an illness or injury, you should notify your supervisor at least one hour before your regularly scheduled work day shift begins – two hours before an evening or night shift.

To be eligible for payment of Paid Sick Leave, proof of your illness may be required. Following your recovery, Montefiore may require that its Occupational Health Service (OHS) physician examine you before you are permitted to return to work.

You may also be eligible to use up to two days of your Paid Sick Leave in a calendar year in case of your child(ren)'s illness.

### For Full-time Registered Nurses

Once you become eligible for this Plan, you accrue 7½ hours of Paid Sick Leave for each calendar month that you work up to a maximum accrual of 900 hours.

If it is determined that you are disabled, short-term disability benefits start on your sixth consecutive workday of absence. You'll receive 100% of your base salary for each day you are absent up to the total number of paid sick days you have accrued.

### For Part-time Registered Nurses

Paid Sick Leave accruals are pro-rated for part-time RNs, based on the percentage of the full-time schedule worked. For example, if you are an eligible part-time RN working 50% of a full-time schedule, you accrue 3.75 hours (50% of 7½) of Paid Sick Leave for each calendar month that you work.

### Paid Sick Leave Accruals

After you receive Paid Sick Leave for five consecutive workdays and it is determined that you are disabled, Montefiore receives the New York State Disability benefits (50% of your annual base earnings up to a maximum benefit of $170 each week for up to 26 weeks in a 52-week period) paid on your behalf from its insurance carrier. If you return to work for the Medical Center, the value of those payments is converted to hours and added to your sick leave accrual up to the amount of sick time accrued prior to being disabled. If you *don't* return to work, you will not receive sick leave accruals for those hours.

## Sick Leave "Buy Back"

The Paid Sick Leave Plan permits you to "buy back" – i.e., receive one hour's regular pay for an hour of accrued sick time as shown in the following table.

| If on November 1st You Have Accrued: | On the Following October 31 You Can "Buy Back:" | For example, if you are a full-time RN and used 15 hours of Paid Sick Leave, you could "buy back" up to: |
|---|---|---|
| more than 90 but less than 450 hours | Up to one-half of the hours accrued but not used during the preceding 12-month period. The maximum number of hours available for "buy back" is 45 hours. Any Paid Sick Leave hours used will reduce the number of hours available for "buy back." | 30 hours |
| more than 450 hours | Hours accrued but not used during the preceding 12-month period. The maximum number of hours available for "buy back" is 90 hours each year. Any Paid Sick Leave hours used will reduce the number of hours available for "buy back." | 75 hours |

The total hours of accrued sick time will be reduced by the number of hours you elect to "buy back."

During November, your supervisor will provide you with a form that shows whether or not you are eligible for a "buy back." If you are eligible and wish to "buy back" sick leave, you must complete and sign the form authorizing the "buy back" and return it to your supervisor as instructed on the form. Montefiore will make every effort to make payment before December 25th of each year.

## Sick Time Bank

The Sick Time Bank (STB) allows you to donate your unused sick time available for "buy back". Donated sick time will provide benefits for nurses who have used their sick time due to a serious illness or injury.

Sick time will be credited to the bank based on its monetary value. For example, if an hour of donated time has a value of $100 and the nurse receiving the time earns sick leave at $50 an hour, then that nurse will receive two hours of donated sick time.

For additional information regarding the Sick Time Bank, contact Montefiore's HR-Benefits Office.

## New York State Disability

After you have exhausted your Paid Sick Leave, as long as it is determined that you continue to be disabled, you will be paid the New York State Disability benefit directly by the insurance carrier (50% of your annual base earnings up to a maximum benefit of $170 each week) for the balance of the 26-week maximum in a 52-week period.

## Supplementary Sick Pay

If it is determined that you are disabled, Supplementary Sick Pay begins after you have used all of your accrued Paid Sick Leave – but in no event before the sixth consecutive workday of your absence. Montefiore provides Supplementary Sick Pay which, in combination with New York State Disability benefits, continues two-thirds of your base salary up to a maximum combined benefit of $280 ($110 *plus* $170) a week.

In no case will Supplementary Sick Pay be paid until Montefiore receives notification of payment from its insurance carrier of New York State Disability benefits. That is why it's important that you, your supervisor and your physician complete and submit the appropriate forms to the HR-Benefits Office as promptly as possible.

## Duration of Payments

Once they begin, STD benefits continue for as long as you remain disabled – but not beyond 52 weeks from the date that you first became disabled.

## Other Benefits during Disability

While you are receiving STD benefits, your Medical, Dental, Flexible Spending Accounts and Life Insurance benefits continue, as long as your salary is sufficient to cover any required contributions, or you arrange to prepay your contributions for these coverages. AD&D Insurance and Dependent Care Flexible Spending Account benefits end when STD benefits end.

The following table shows how your coverages may be continued after STD benefits end.

| After STD Benefits Stop, To Continue: | You Must: |
|---|---|
| Medical Coverage* | |
| · For you and your covered family members at the time you became disabled, if you remain disabled and your LTD claim is not approved | Elect **COBRA** and pay the required premium. |
| · For you and your covered family members at the time you became disabled, if you remain disabled and your LTD claim is approved | Your coverage will continue, at no cost to you, for you and your covered family members subject to plan eligibility provisions up to 24 months from your date of disability or until you become eligible for Medicare, if earlier. When coverage stops, you may elect **COBRA**.<br>Generally, to become eligible for Medicare, you must have received Social Security disability benefits for 24 months, or have permanent kidney failure. You must apply for Social Security disability benefits. |
| Dental coverage for you and your family members | Elect **COBRA** and pay the required premium. |
| Healthcare Flexible Spending Account | Make contributions on an after-tax basis for the rest of that calendar year. |
| Life Insurance | Convert to an individual insurance policy if you are age 70 or older when you become disabled. If you are under age 70 when you become disabled, Life Insurance continues at no cost to you until you reach age 70, then you can convert to an individual policy. |
| * If you contract the HIV virus as a result of your employment with Montefiore and become eligible for Workers' Compensation benefits, Medical coverage for you will continue until you become eligible for Medicare – but in no case longer than 29 months. When Medical coverage stops, you can elect **COBRA** if you are not eligible for Medicare for whatever time remains under the COBRA provisions. | |

## Claiming Benefits

If you are absent from work, you should notify your supervisor immediately. He or she will arrange to send you the appropriate form for claiming benefits for Supplementary Sick Pay and New York State Disability benefits, if your absence is expected to continue for more than seven calendar days. The form must be completed by you, your supervisor and your doctor and submitted to Montefiore's HR-Benefits Office within 10 days of the date your disability begins.

You should be aware that if you terminate employment for any reason other than disability, and you become disabled during the four weeks after your termination, you may be eligible for New York State Disability benefits.

## Termination of Coverage

Paid Sick Leave and Supplementary Sick Pay stop on the day you leave Montefiore for any reason. New York State Disability benefits may continue.

# 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 Registered Nurses Benefits Program is the Montefiore Medical Center Employee Health & Welfare Benefit Plan.

## Plan Sponsor

The sponsor of the Plan and its component benefits in the Registered Nurses Benefits Program is:

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

## Plan Administrator

The Plan Administrator for the Registered Nurses Benefits Program 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 is 13-1740114.

## Claim Denials and Appeals

You must file a claim to receive benefits from the Plans in the Registered Nurses Benefits Program. 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: |
|---|---|
| RN Health Plan | Empire BlueCross BlueShield<br>PO Box 1407, Church Street Station<br>New York, NY 10008-1407<br>**866.236.6748** |
| Employee Assistance Program (EAP) | HealthCare EAP<br>ESI/Longview Associates<br>800.666.5EAP |
| RN Dental Benefits<br>Dental Health Maintenance Organization (DHMO) | Cigna Healthcare<br>P.O. Box 188037<br>Chattanooga, TN 37422-8037<br>**800.Cigna24 (800.244.6224).** |
| Prescription Drugs | Express Scripts<br>100 Parsons Pond Drive<br>Franklin Lakes, NJ 07417-2603<br>**800.631.7780** |
| Flexible Spending Accounts | WageWorks<br>PO Box 14053<br>Lexington, KY 40511<br>**877.924.3967** |
| Life Insurance<br>Accidental Death and Dismemberment Insurance | Securian Financial Group, Inc.<br>Group Insurance<br>400 Robert Street North<br>St. Paul, MN 55101-2098<br>888.658.0193 |
| Business Travel Accident | Gerber Life Insurance Company<br>c/o A.C. Newman & Company,<br>7060 North Marks Avenue, Suite 108,<br>Fresno, CA 93711-0269<br>**559.252.2525** |
| Paid Sick Leave and Supplementary Sick Pay | Montefiore Medical Center<br>111 East 210th Street<br>Bronx, NY 10467-2490 |
| Long-term Disability | Principal Life Insurance Company<br>Attn: Group Life & Disability Claims Department<br>Des Moines, IA 50392-0002<br>**800.245.1522** |

## 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, healthcare 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 or dental 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, 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 Medical 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 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 also outlined in the current agreement between Montefiore and the following union representing registered nurses:

New York State Nurses Association
11 Cornell Road
Latham, NY 12110-1403

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

## Administrative Information

| Official Plan Name | Plan Number | Plan Administrator/Insurance Company | Plan Funding |
|---|---|---|---|
| Montefiore Medical Center Employee Health & Welfare Benefit Plan | 505 | *Registered Nurses Health Plan:*<br>Empire BlueCross BlueShield<br>PO Box 1407, Church Street Station<br>New York, NY 10008-1407<br>866.236.6748 | Registered Nurse and Montefiore contributions |
| | | *HealthCare EAP:*<br>ESI/Longview Associates<br>800.666.5EAP | Montefiore contributions |
| | | *Prescription Drug*:<br>Express Scripts<br>100 Parsons Pond Drive<br>Franklin Lakes, NJ 07417-2603<br>800.631.7780 | Registered Nurse and Montefiore contributions |
| | | *Registered Nurses Dental Benefits/DHMO*:<br>Cigna Healthcare<br>P.O. Box 188037<br>Chattanooga, TN 37422-8037<br>800.Cigna24 (800.244.6224) | Registered Nurse and Montefiore contributions |
| | | *Flexible Spending Accounts*:<br>WageWorks<br>PO Box 14053<br>Lexington, KY 40511<br>877.924.3967 | Registered Nurse contributions |
| | | *Life and AD&D Insurance:*<br>Securian Financial Group, Inc.<br>Group Insurance<br>400 Robert Street North<br>St. Paul, MN 55101-2098<br>888.658.0193 | Registered Nurse and Montefiore contributions |
| | | *Business Travel Accident Insurance:*<br>Gerber Life Insurance Company<br>c/o A.C. Newman & Company,<br>7060 North Marks Avenue, Suite 108,<br>Fresno, CA 93711-0269<br>559.252.2525 | Montefiore contributions |
| | | *Long-term Disability:*<br>Principal Life Insurance Company<br>Attn: Group Life & Disability Claims Department<br>Des Moines, IA 50392-0002<br>800.245.1522 | Montefiore contributions |
| | 583 | *Supplementary Sick Pay:*<br>Montefiore Medical Center<br>111 East 210 Street<br>Bronx, NY 10467 | Montefiore contributions |
| | N/A | *Paid Sick Leave*:<br>Montefiore Medical Center<br>111 East 210 Street<br>Bronx, NY 10467 | Montefiore contributions |

## Plan Type and Plan Year

The following table shows the Plan year on which 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 |
| 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 |
| Business Travel Accident Insurance | Welfare providing business travel life and accident benefits | January 1 to December 31 |
| Paid Sick Leave | Welfare providing short term disability benefits | January 1 to December 31 |
| Supplementary Sick Pay | Welfare providing short term disability benefits | January 1 to December 31 |
| Long-term Disability | Welfare providing long term disability 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 each Plan's description (which is 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

Subject to collective bargaining, Montefiore expects and intends to continue the Medical, Dental, Flexible Spending Accounts, Life Insurance and Accidental Death and Dismemberment Insurance, Business Travel Accident and Disability 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 Medical Center 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 and/or Dental benefits are terminated, you will not have the right to any benefits or have any further rights – other than 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 Registered Nurses 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 work sites 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 the 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 your 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**.