Montefiore

Registered Nurses (1199) Benefits Program

2013 Summary Plan Description

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Health Care Flexible Spending Account (FSA) allows you to pay for certain eligible expenses with dollars that are *never taxed*. It expands your benefit program and strengthens the level of your coverages by reimbursing you for expenses which may not otherwise be covered under other plans.

This is a Summary Plan Description (SPD) of the Health Care Flexible Spending Account (FSA) Plan in effect on January 1, 2013. This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It explains when you become eligible for benefits, what the plans cover, any benefit limitations that apply, how to file claims and where to obtain additional information.

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 you elect to have deposited into your Health Care FSA. These contributions come out of your pay before it is taxed, thereby reducing your taxable income.

Eligible Dependents – Your spouse and any individuals you claim as dependents on your federal income tax return – whether or not they are enrolled in Montefiore's medical or dental plans

Eligible Health Care Expenses – Those expenses listed in IRS Publication 502 as eligible for reimbursement through Health Care Flexible Spending Accounts.

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) 378-6531**. The mailing address is:

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

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. Proof of marriage in a state other than the one in which the couple resides will also be accepted.
- Are unable to marry because of laws prohibiting marriage to persons of the same sex in the state of your legal residence and:
  - Are of the age of consent in your state of legal residence and competent to enter into a contract
  - Are not so closely related that marriage would otherwise be prohibited
  - Are not legally married to any other person
  - Are the sole domestic partners of each other
  - Live together, share the common necessities of life and are responsible for each other's common welfare, including financial interdependence.

  You must file an "Affidavit of Domestic Partnership" with Montefiore's HR-Benefits Office and submit documentation to establish eligibility. The affidavit is available from Montefiore's HR-Benefits Office or on the Benefits Website at **www.mymontebenefits.com**.

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

WageWorks – The Claims Administrator for the Health Care Flexible Spending Account.

ELIGIBILITY

You are eligible to enroll in the Health Care Flexible Spending Account (FSA) if you are employed by Montefiore Medical Center in an eligible position covered by a collective bargaining agreement with Local 1199 SEIU United HealthCare Workers East 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.

YOUR COST FOR COVERAGE

You make all the contributions necessary to fund your Health Care FSA 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.

Any contributions are deducted from your bi-weekly paycheck.

HOW TO ENROLL

When you are hired – and each year during the fall annual election period – you will have the opportunity to enroll in the Health Care FSA.

Enrolling is easy! Log on to the Benefits Website at **www.montebenefits.com** *or* Call the Benefits Enrollment Call Center, available Monday through Friday between 8am and 8pm EST at **(888) 860-6166** to speak with an enrollment specialist.

WHEN COVERAGE BEGINS

Coverage begins if you are eligible and are a:

- Regular full-time or eligible part-time RN – The first day of the month coincident with or after your date of employment provided you have enrolled
- Temporary full-time or eligible part-time RN – The first day of the month coincident with or after you complete three consecutive months of employment provided you have enrolled

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, Internal Revenue Service (IRS) rules restrict your ability to change your Health Care Flexible Spending Account decision at any time other than during the fall annual election period, unless you experience a qualified change in status.

Qualified status changes include:

- Your marriage, divorce, legal separation or annulment
- Establishment or termination of a qualified domestic partnership
- Birth, adoption or legal guardianship of a dependent child
- Death of a family member
- 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, your spouse's, qualified domestic partner's or dependents' position or schedule that makes you or them ineligible for coverage

  or

- Change from a non-participating part-time to a full-time North Division RN.

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
- 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. Payroll adjustments will be reflected in the first paycheck you receive after Montefiore's HR-Benefits Office has been notified that the new election is effective.

YOUR FLEXIBLE SPENDING ACCOUNT

The Health Care Account is used to pay you for unreimbursed health care 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, over-the-counter medicines, 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.

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

HOW A HEALTH CARE FSA SAVES YOU MONEY

The Health Care FSA funded with before-tax contributions deducted from your pay, lowers 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).

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

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

[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 2012 is $110,100.

YOUR CONTRIBUTIONS

When you enroll, you decide how much, if anything, to contribute to your Health Care Flexible Spending Account. You can make an annual contribution from $130 to $2,500.

SPECIAL RULES TO CONSIDER

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

- Once you establish a Health Care 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.
- To reduce the possibility of forfeitures, IRS rules permit you to apply to apply eligible expenses incurred through March 15th against any remaining balance in your prior year's Health Care Account.
- If you are newly eligible or have a qualified change in status and enroll in a Health Care Account during the year, only expenses incurred while you are making contributions to the FSA 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 Health Care Flexible Spending Account because of the tax savings.

  For example, let's assume you estimate that your out-of-pocket health care 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.

ELIGIBLE HEALTH CARE EXPENSES

You can be reimbursed for those health care 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 health care 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 teach 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.

IRS Publication 502 contains a complete list of health care 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**.

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 (as treatment 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 of specialized orthopedic shoe over like non-specialized shoe)
- Propecia
- Reconstructive surgery (following accident, medical procedure or condition)
- Retin-A (for non-cosmetic purposes)
- Special equipment
- Special foods (gluten-free, salt-free or other 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**.

HEALTH CARE EXPENSES NOT ELIGIBLE

Expenses *not* eligible for reimbursement include:

- Baby sitting, 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.

CLAIMS REIMBURSEMENT

WageWorks is the Claims Administrator for the Health Care Flexible Spending Account. WageWorks provides a variety of ways to access the funds in your account, such as:

- WageWorks Health Care Card – The Health Care Card may be used to pay for eligible health care 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 Health Care Card will carry your current year account balance.
  - When you use your WageWorks Health Care 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 Health Care Account – you must select the credit button when you swipe your card.
  - Your Health Care 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 health care 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. Health Care 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.

You should retain any receipts associated with eligible health care expenses, as WageWorks may periodically ask for documentation of expenses to comply with IRS audit requirements. If you request reimbursement of an amount greater than your Health Care 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.

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.

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.

Right of Recovery

If you are paid more than you should be under the Plan, you are obligated to repay that amount to the Plan. The Plan Administrator may withhold payment of your claims until your submitted claims total the amount owed and/or ban you from further Plan participation.

OTHER IMPORTANT INFORMATION

If You Leave Montefiore

Health Care 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 Health Care 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.

In Case of Your Death

Health Care Account

If you die with a Health 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 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 Health Care 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.

When Coverage Ends

Your FSA participation ends if:

- you do not re-enroll during the annual enrollment period
- you go on an unpaid leave of absence (unless you elect to continue your Health Care Account through COBRA continuation coverage)
- your employment terminates for any reason including retirement or death.

If your FSA participation terminates, you have 90 days to continue to submit claims for expenses incurred up to and including the date your participation terminates (up to the maximum amount of your annual election, less amounts already paid to you). Any unused balance remaining in your account after all claims have been submitted will be forfeited.

Continuation Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health 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.

You can elect to continue coverage if your participation in the Health Care FSA stops as a result of one of the following "qualifying events:"

- Termination of employment for reasons other than gross misconduct
- Your death.

You and/or your qualified beneficiaries can individually elect to continue contributions to your Health Care Account on an after-tax basis and submit claims through that account for eligible expenses incurred from the date your participation terminated until the end of the Plan year.

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

Montefiore has the responsibility to notify the COBRA Administrator in case of your death or termination of employment within 31 days of the event. Once the COBRA Administrator is notified, they will notify you that you have the right to choose continuation coverage.

If you choose continuation coverage, your coverage under the Health Care FSA will be the same as it would have been had you not lost coverage.

You have 45 days from the date of the initial election to make your first after-tax payment. Subsequent payments are due on the payment due date, and must be paid in full within the 30-day grace period.

Duration of Coverage

COBRA coverage for the Health Care FSA continues until the end of the calendar year. However, your Health Care FSA COBRA coverage may stop before the end of the calendar year for any of the following reasons:

- Montefiore no longer provides flexible spending accounts to any of its associates
- You do not make the payments for continuation coverage in a timely manner
- You become covered under another flexible spending account plan.

Once continuation coverage stops for any reason, it cannot be reinstated.

If You Have Questions

For more information about your rights and obligations under the Plan 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) 502-6272
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.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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*** – You can use a certificate of creditable coverage to eliminate or reduce any pre-existing condition limitation period under another group health care 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 health care coverage

    or
  - up to 24 months after losing health care 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)
    - you acquire a new family member through marriage, establishment of domestic partnership, 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 health care professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to health care.

    Covered providers may use or share only the minimum amount of protected information needed for a particular purpose. You have to sign a specific authorization before your medical information can be released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your health care. Covered providers must first obtain your specific authorization before disclosing your medical information for marketing.
  - *Access To Medical Records* – HIPAA gives you the ability to review and obtain copies of your medical records. 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.
- *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 Medical Center privacy practices to:

  Health Plan Privacy Officer
  HR – Benefits Office
  Montefiore Medical Center
  111 East 210th Street
  Bronx, NY 10467-2490
  Telephone: **(914) 378-6531**

  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 **1-866-444-3272**. You can find additional HIPAA information on the Internet at **www.hhs.gov/ocr/hipaa**.

ERISA ADDITIONAL INFORMATION

This section contains information about how the Plan is 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. If there are any discrepancies between the information contained in this SPD and the official written Plan documents, the Plan documents will govern.

Plan Sponsor

The sponsor of the Plans is:

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

Plan Administrator

The Plan Administrator is:

Vice President, Human Resources
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490
(914) 378-6531

Claims Administrator

The Claims Administrator is:

WageWorks
PO Box 14053
Lexington, KY 40511
(877) 924-3967 **www.wageworks.com**

Claims and Appeal Procedures

Generally, WageWorks will make a decision within seven to 10 days after receipt of your claim. In the event of special circumstances, WageWorks may extend the period for a determination for up to an additional 15 days, in which case, WageWorks will send you a written notice stating the reasons for the delay and the expected date of the decision before the end of the 15-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the date of the extension notice to provide that information. The time period during which WageWorks must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

If your claim for benefits is denied, in whole or in part, you will receive a written explanation, which will include:

- the specific reasons for the denial of your claim
- the specific references in the FSA Plan document that support those reasons
- the information you must provide to verify your claim and the reasons why that information is necessary
- the procedure available for further review of your claim
- any internal rule, guideline, protocol or other similar criterion that was relied on in denying your claim or a statement that a copy of such internal rule, guideline, protocol or other similar criterion will be provided free of charge to you on request.

Your Right to Appeal

You have the right to appeal a denial of your claim. Within 60 days after receipt of a notice of denial, you may make a written request for review of such denial by addressing your request to:

WageWorks
PO Box 14053
Lexington, KY 40511

In preparing your appeal, you may include any written comments and relevant information, even if such materials were not submitted or considered in the initial benefit determination. The FSA Plan shall permit you, upon request and free of charge, reasonable access to any information pertinent to your claim. The FSA Plan also will identify any health care professional consulted in the claim.

You must submit a written appeal to WageWorks within 180 days after you receive the claim denial notice.

WageWorks will conduct a full and fair review of your appeal and will notify you of the decision within 60 days. In conducting the appeal, WageWorks, if appropriate, will consult a health care professional. Such professional will not be the same individual or a subordinate of any individual consulted in the initial claim determination. The persons reviewing your claim appeal on behalf of WageWorks will not be the individuals (or their subordinates) who made the initial determination. The initial determination will not be afforded any deference.

If your appeal is denied, in whole or in part, the decision will be in writing, and will include:

- the specific reasons and the FSA Plan references on which the decision is based
- a statement informing you of your right to reasonable access to all relevant documents
- an explanation of what to do to have the decision reviewed if your appeal is denied, including a statement of your right to bring a civil action under the terms of the Plan or under section 502(a) of ERISA
- any internal rule, guideline, protocol or other similar criterion that was relied on in denying your claim or a statement that a copy of such internal rule, guideline, protocol or other similar criterion will be provided free of charge to you on request

- if the determination is based on a medical necessity or experimental treatment or other limit, an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided free of charge to you on request
- 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."

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

Any failure on your part to comply with WageWorks request for information may result in a delay or denial of your claim.

You cannot file suit in federal court until you have exhausted these appeals procedures. If the FSA Plan fails to follow the claims review procedures at any point during the process, however, such as by failing to respond to your benefit claim or appeal, you will be deemed to have exhausted the remedies available under the FSA Plan and you will be entitled to bring a civil action.

WageWorks has the authority to make final decisions with respect to paying claims under the FSA Plan.

Employer Identification Number

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

Legal Service

Legal process may be served on the Plan Administrator, who is the Vice President, Human Resources, Montefiore Medical Center, 111 East 210th Street, Bronx, New York 10467-2490 and, in addition, on the Plan Trustee and/or the insurance company.

Union Agreement

The benefits described in this SPD are also outlined in the current agreement between Montefiore Medical Center and the following union representing North Division registered nurses:

Local 1199 SEIU United HealthCare Workers East, Registered Nurses Division
310 West 43rd Street
New York, New York 10036-6977

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 Administrator/Insurance Company	Plan Number	Plan Funding
Montefiore Medical Center Health Care Flexible Spending Account	WageWorks PO Box 14053 Lexington, KY 40511 **(877) 924-3967**	505	Registered Nurse 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
Health Care Flexible Spending Account	Welfare providing tax-free reimbursement of eligible health care expenses	January 1 to December 31

Plan Documents

This Summary Plan Description describes only the highlights of the Health Care Flexible Spending Account 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 each 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 Health Care Flexible Spending Account Plan indefinitely, but reserves the right to change, modify or terminate the Plan, through its Board of Trustees, in whole or in part, at any time and for any reason subject to collective bargaining.

Your Rights Under ERISA (Employee Retirement Income Security Act of 1974)

The benefits provided by the Health Care Flexible Spending Account 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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**.