RETIRED MANAGEMENT BENEFITS PROGRAM
2017 SUMMARY PLAN DESCRIPTION

Montefiore

Introduction

As a retiree of Montefiore Medical Center® (also referred to as "Montefiore"), you may be eligible for continuing healthcare and life insurance protection.

This is a Summary Plan Description (SPD) of the Retiree Benefits Program. It is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

This SPD provides a description of the plans in effect on January 1, 2017. It explains when you become eligible, what benefits the plans pay, any benefit limitations that apply, how to file claims and where to obtain additional information.

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 and annual updates for these plans. Prior Summary Plan Descriptions and updates should be discarded.

Information about each of the plans that make up the Retiree Benefits Program – and how the plans work – can be found in the following sections.

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 58 for more details.

If you and/or your dependents are Medicare-eligible, Federal law offers more choices for prescription drug coverage. See page 35 for more details.

Eligibility and Enrollment

The Retiree 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

Claims Administrator – The company contracted by Montefiore to supervise the processing of claims and administration of the Retiree Health Plan and Insured Benefit Plan.

Exempt Associate – You were an exempt associate if while employed at Montefiore you were exempt from the minimum wage and overtime provisions of the Fair Labor Standards Act of 1938, as amended.

Full-time Associate – You were a full-time associate if while employed at Montefiore you were regularly scheduled to work 100% of a full-time schedule and worked full-time for the 10 years immediately prior to your retirement.

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

Non-exempt Associate – You were a non-exempt associate if while employed at Montefiore you were covered by the overtime pay provisions of the Fair Labor Standards Act of 1938, as amended. Non-exempt employees include hourly-paid employees and some non-exempt salaried workers, such as clerical and support positions.

Part-time Associate – You were a part-time, benefits-eligible associate if while employed at Montefiore you were regularly scheduled to work at least 50% but less than 100% of a full-time schedule and worked part-time during any portion of the 10-year period immediately prior to your retirement.

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

Eligibility for Retiree Benefits

If you are currently retired and participating in the Montefiore Medical Center Retiree Health Plan and/or the Montefiore Medical Center Insured Benefit Plan, your participation continues – provided you continue to make any required contributions on a timely basis.

Otherwise, you are eligible for the Retiree Benefits Program if you retire from Montefiore as a security guard, non-union clerical associate, physical therapist or exempt associate and meet the requirements outlined below.

If you retire on or after January 1, 2004 and are:	**At the time of your retirement from Montefiore you:**
· A security guard, non-union clerical associate or a physical therapist	· participated in Montefiore's Benefits Program (including waiver of coverage if you were a full-time associate at the time of the waiver) for at least 10 consecutive years immediately prior to your retirement *and* · are age 60 or older.
· An exempt associate	· participated in Montefiore's Benefits Program (including waiver of coverage if you were a full-time associate at the time of the waiver) immediately prior to your retirement *and* · are age 60 or older *and* · have completed at least 10 years of service.

The following retirees are not eligible for the Retiree Benefits Program:

- Registered Nurses who immediately prior to retirement worked in a position covered by a collective bargaining agreement with the New York State Nurses Association (NYSNA)
- Retirees who immediately prior to retirement worked in a position covered by a collective bargaining agreement with the National Health and Human Service Employees (1199)
- Retirees eligible for any other plan providing health and life insurance benefits offered by Montefiore
- Leased employees
- Independent contractors
- Any retiree who immediately prior to retirement was not treated as an employee for payroll purposes even if a court or administrative agency determines that such an individual was an employee rather than an independent contractor

  and

- Any retiree who does not meet the eligibility criteria.

Your family members are eligible for benefits under the Montefiore Medical Center Retiree Health Plan if they were covered as eligible dependents under your policy by one of the medical and/or dental options available under Montefiore's Benefits Program immediately prior to your retirement.

If you remarry your new spouse and any new dependent children will not be eligible for coverage.

Family members include your spouse and unmarried dependent children of you or your spouse whom you can cover December 31 of the year they reach age 26.

If, at the time you retired, you had a stepchild, legally adopted child, or a child for whom you were legal guardian and the child was covered by one of the medical and/or dental options available under Montefiore's Benefits Program while you were an active associate, that child will continue to be eligible, as long as he or she meets the age and dependency requirements. Coverage can be continued beyond the ages shown above for an eligible child who is disabled or while covered as your dependent under the Montefiore Medical Center Retiree Health Plan becomes disabled as determined by the Claims Administrator. You will be required to provide a physician's statement certifying the child's handicap and provide periodic proof thereafter, as requested by the Claims Administrator. Coverage will continue while you remain covered by the Montefiore Medical Center Retiree Health Plan for as long as the child remains disabled and continues to qualify as your dependent. To apply for this continuing coverage, you must notify Montefiore's HR-Benefits Office in writing at least 30 days before the child's coverage would otherwise end.

If a covered spouse or dependent child is no longer eligible, you must notify Montefiore's HR-Benefits Office in writing by submitting the required forms within 30 days.

If you and your spouse both worked for Montefiore:

- You and your spouse cannot be covered both as a retired associate and as a dependent of a retired associate
- Your children cannot be covered as dependents of both you and your spouse.

If one of you is an active associate and one is a retired associate, neither you nor your eligible family members can be covered under both active and retiree health plans.

Your Cost for Retiree Coverage

Contribution rates for Retiree Medical and Dental coverage change periodically. If Retiree Medical and/or Dental costs increase or decrease after your retirement date, the share of the cost you and/or your surviving family members must pay will be adjusted to reflect those changes.

Contributions may be made monthly, quarterly, semi-annually or annually in advance. Contact the Claims Administrator for current rates and to make the necessary arrangements.

For Retiree Medical

Whether or not you contribute for Retiree Medical coverage for yourself and any enrolled family members depends on the date you retire, your age, status and years of service.

For each Medicare-eligible participant *and/or* family member who contributes toward the cost of coverage, Montefiore has established an annual maximum covered premium dollar limit or "cap" which limits its contributions to Basic Retiree Medical (Option 1). Here is how the cap works.

When the gross cost of Basic Retiree Medical (Option 1) coverage exceeds $4,000:

- Montefiore's maximum contribution will be $3,200 (80% of $4,000)
- Medicare-eligible retirees who are required to contribute for coverage will pay the remaining $800 balance (20% of $4,000) plus 100% of any amount in excess of the $4,000 cap.

If you elect Basic Retiree Medical *Plus* Supplement (Option 2), your contributions begin for each individual when they become eligible for Medicare. So, for example, if you elect Option 2 and are age 65 with a spouse age 63, you make your contribution (if any) for Option 1 *plus* the full difference in cost between Option 1 and Option 2 for yourself only. Once your spouse reaches age 65, his or her Option 2 coverage and contributions begin.

For Retiree Dental

If you enroll for Retiree Dental coverage, you pay the full cost for you and your eligible family members.

For Retiree Life Insurance

Montefiore currently pays the full cost of Retiree Life Insurance.

How to Enroll

For Retiree Medical Coverage

You must enroll for Retiree Medical coverage at the time you retire. If you do not enroll when you are first eligible – or if you enroll and then cancel coverage – you will not be able to enroll for Retiree Medical coverage in the future. Retiree Medical coverage provides two options:

- **Basic Retiree Medical (Option 1)** is available to all eligible retirees and covered family members regardless of age.
- **Basic Retiree Medical *Plus* Supplement (Option 2)** is available to Medicare-eligible participants – generally age 65 or older. When you (or your spouse) first become Medicare-eligible, you will have a one-time opportunity to enroll in Option 2, as shown in the table below. If you do not enroll in Option 2 at that time, you will not have another opportunity to choose this supplemental coverage.

If you retire:	**You will have a one-time opportunity to enroll in Basic Retiree Medical *Plus* Supplement (Option 2):**
· Before age 65 and elect single coverage	· When you become Medicare-eligible
· Before age 65 and cover your spouse or qualified domestic partner	· When the first of you becomes eligible for Medicare – or at retirement if your spouse or qualified domestic partner is then Medicare-eligible
· At age 65 or later whether or not you cover your spouse or qualified domestic partner	· When you retire*
* If you are covered by Medicare and your spouse is not, your spouse will be covered by Option 1 until he or she becomes Medicare-eligible.	

CHANGING YOUR RETIREE MEDICAL ELECTION

The only change you can make to your Retiree Medical election is to switch from Option 2 to Option 1. Once you make this change, you will not be able to elect Option 2 in the future.

You can cancel coverage at any time. However, if you do, you will not be able to elect coverage in the future.

For Retiree Dental Coverage

You must enroll for Retiree Dental coverage at the time you retire. If you do not enroll when you are first eligible – or if you enroll and then cancel coverage – you will not be able to enroll for Retiree Dental coverage in the future.

CHANGING YOUR RETIREE DENTAL ELECTION

The only change you can make to your Retiree Dental election is to cancel coverage.

For Retiree Life Insurance

When you retire, you are automatically enrolled for Retiree Life Insurance if you meet the eligibility requirements and have Montefiore-provided Life Insurance in effect on the day before you retire.

When Coverage Begins

Retiree Medical, Dental and Life Insurance coverages begin on the first day of the month coincident with or after your first day of retirement, provided you complete and submit the required forms to Montefiore's HR-Benefits Office before then. You must also make any required contributions on a timely basis.

The Montefiore Medical Center Retiree Health Plan

The Montefiore Medical Center Retiree Health Plan provides valuable financial protection when you or a covered family member needs medical or dental care. It is made up of two parts:

- Retiree Medical Benefits

  and

- Retiree Dental Benefits.

Your medical coverage provides benefits only for covered services and supplies that are medically necessary for the treatment of a covered illness or injury and legal in the state in which they are obtained. ***Only those services and supplies specifically listed as covered in this SPD are eligible for reimbursement through Montefiore's Retiree Health Plan.***

What the Retiree Health Plan 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 maximum dollar amount you have to pay for eligible medical expenses up to R&C limits in any calendar year in addition to your deductible and copayments. Expenses above R&C limits are not counted in determining whether you have reached the out-of-pocket maximum and are not reimbursed once the out-of-pocket maximum is met.

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 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.

Cigna – The Claims Administrator for dental benefits. Cigna is not the Claims Administrator for medical or prescription drug benefits or Life Insurance.

Cigna Network – A national network of dentists and specialists, which can be accessed online at Cigna.com. For a more personalized website, sign up at **my.Cigna.com**. Cigna Customer Service is available at 800.Cigna24 (800.244.6224).

Coinsurance – The percentage of the cost you pay for covered expenses under the Montefiore Medical Center Retiree Health Plan or any other sources of medical and 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 health coverage for a specified period of time by paying the full premium plus a 2% administrative charge.

Coordination of Benefits (COB) – A provision included in Basic Retiree Medical *Plus* Supplement (Option 2) that applies when you or a dependent is entitled to benefits from two or more sources – i.e., Medicare, Option 2 and/or another source of medical payments, such as an employer-sponsored health plan or automobile insurance. Under the COB provision, benefits payable from all sources combined are limited to 100% of covered expenses. Retiree Dental coverage also includes a COB provision.

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, administration of oral medicines or other services, which can be provided by someone other than a trained healthcare provider.

Deductible – The amount you must pay each calendar year before benefits for certain covered services are paid. Separate deductibles apply to Medical and Dental coverage.

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

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

Empire Behavioral Health Network – A network of providers who specialize in providing mental health and substance abuse counseling and treatment to retirees enrolled in the Retiree Health Plan.

Empire BlueCross BlueShield (Empire) – The Claims Administrator for medical coverage. Empire is not the claims administrator for dental or prescription drug benefits or life insurance.

Empire 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.

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

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

Express Scripts – The Claims Administrator for prescription drug benefits.

Formulary – A 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 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.

Health Maintenance Organization (HMO) – A group of local healthcare professionals and facilities that provide medical care. Most HMOs cover a wide range of medical services and typically require a copayment for office visits and certain other 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 one 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, and one volunteer and have a volunteer program. A hospice is *not* a facility which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics or a hotel or similar institution.

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

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, which can safely be provided on an inpatient or outpatient basis.

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

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

Medicare – The health program provided under Title XVIII of the Social Security Act.

Montefiore Medical Group – A division of Montefiore Medical Center 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.

Montefiore Integrated Provider Association (MIPA) – A network of providers established by the Contract Management Organization (CMO) of Montefiore Medical Center. The HR-Benefits Office does not participate in selecting physicians who join the MIPA. The MIPA ensures physicians' credentials. This type of arrangement is called a Preferred Provider Organization (PPO). MIPA physicians must be board-certified or board-eligible and must meet MIPA standards. Montefiore contracts with the MIPA under the Retiree Health Plan for provider services only. You can call the CMO Provider Relations Department at **(914) 377-4500**.

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.

Non-duplication of Benefits – A provision of Basic Retiree Medical (Option 1) which applies when health benefits are payable from two or more sources – i.e., Medicare, Option 1 and/or another employer-sponsored medical plan. The provision limits payments from all sources to the amount that Basic Retiree Medical benefits would have paid had there been no other coverage.

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.

Participating Pharmacy – A pharmacy which has contracted with Express Scripts to provide prescription drug 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. Charges in excess of R&C and beyond medical maximum limitations are *not* covered by the Retiree Health Plan.

The Reasonable and Customary payment schedule does not apply to services provided by Montefiore Medical Group (MMG) primary care physicians, physicians in the Montefiore Integrated Provider Association (MIPA), Empire Behavioral Health Network, Empire BlueCross BlueShield Traditional Indemnity Network and dentists in the Empire Dental Premium Care PPO Network.

Separate Admission – Time spent as an inpatient in an approved facility. Two or more periods of confinement are considered separate if they are due to unrelated causes or separated by 90 days following discharge – or for working family members, separated by a return to active work for one day.

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

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

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

Subrogation – The right of the Montefiore Medical Center Retiree Health Plan to recover medical or dental expenses paid to the participant for an illness or injury 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 injury 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 retiree 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, which provides a program for the diagnosis, evaluation and effective treatment of substance abuse, including detoxification and infirmary-level medical services. The treatment must be provided by licensed nurses under the direction of a full-time registered nurse and the supervision of a staff of physicians. The facility must also prepare and maintain a written treatment plan for each patient based on the patient's medical, psychological and social needs.

An Overview of Your Retiree Medical Benefits

Medical benefits under the Montefiore Medical Center Retiree Health Plan include:

- Hospital benefits – which pay for covered expenses such as semi-private hospital room and board and certain alternatives to in-hospital care
- Medical/Surgical benefits – which help pay the cost of medical services and supplies – after the annual deductible

  and

- Prescription Drug benefits – which help pay the cost of prescription drugs obtained at a participating Express Scripts retail pharmacy or home delivery pharmacy service.

Your Retiree Medical Options

Montefiore offers Basic Retiree Medical (Option 1) to all eligible retirees and family members. In addition, once you and/or your family members become Medicare eligible, you have a one-time opportunity to elect Basic Retiree Medical *Plus* Supplement (Option 2)

The difference between Option 1 and Option 2 is how each option pays benefits if you and your covered family members are covered by Medicare or another group medical plan.

Basic Retiree Medical (Option 1) contains a non-duplication of benefits provision. Non-duplication of benefits limits payments from Medicare and any other group coverage to the amount that Basic Retiree Medical (Option 1) would have paid (subject to reasonable and customary amounts and other limits) had there been no other coverage.

Basic Retiree Medical Plus Supplement (Option 2) contains a coordination of benefits (COB) provision. Coordination of benefits (COB) limits the combined payments from Medicare and any other group coverage to 100% of covered expenses. Basic Retiree Medical *Plus* Supplement (Option 2) will pay the difference between the other plan's benefit and 100% of the covered expense (subject to reasonable and customary amounts and other limits) but not more than it would pay if it were the only plan.

For example, let's assume Montefiore's retiree medical benefits normally pay $800 toward a $1,000 covered expense. Here is how Option 1 and Option 2 would determine benefits.

<table>
<tr><th>If Medicare or other group coverage pays benefits that are:</th><th colspan="2">Montefiore's Basic Retiree Medical (Option 1):</th><th colspan="2">Montefiore's Basic Retiree Medical Plus Supplement (Option 2):</th></tr>
<tr><td>Equal to or greater than Montefiore's retiree medical benefits would pay for that expense</td><td>Will not pay any further benefits</td><td>Medicare pays $800
Option 1 pays $0</td><td rowspan="2">Will pay the difference between the other plan's benefit and 100% of the covered expense but not more than it would pay if it were the only plan</td><td>Medicare pays $800
Option 2 pays $200</td></tr>
<tr><td>Less than Montefiore's retiree medical benefits would pay for that expense</td><td>Will pay the difference between the plan's benefit and the amount you received from the other coverage</td><td>Medicare pays $600
Option 1 pays $200
($800 - $600)</td><td>Medicare pays $600
Option 2 pays $400
(If Medicare paid less than $200, the maximum benefit Option 2 would pay is $800 for that expense)</td></tr>
</table>

If You are Medicare-eligible

If you are Medicare-eligible, your Montefiore retiree medical benefits are determined assuming you are enrolled in both Parts A and B of Medicare – or a Medicare option. You must comply with all requirements imposed by the Medicare option you select. You should also be aware that this Plan will not pay charges that are denied by Medicare as a result of your failure to comply with Medicare pre-admission or second surgical opinion requirements.

If you are a Medicare participant and use Medicare providers, Retiree Medical coverage will reimburse the following expenses, if applicable:

- The Medicare deductible for in-hospital care
- The Medicare copayment for the 61st through the 90th day of in-hospital care in a semi-private room
- The Medicare copayment for the 91st through the 150th day (60-day lifetime reserve) of in-hospital care in a semi-private room
- Semi-private hospital room, board and other services for the 91st through the 120th day of confinement
- Accidental injury or emergency occurring outside of the United States
- Outpatient prescription drugs (if you are not enrolled in Medicare's prescription drug coverage)

  and

- Outpatient psychiatric care.

Treatment Using Medicare Providers

If you are Medicare-eligible, you should use providers who accept Medicare assignment. When doctors and suppliers agree to accept assignment they accept the Medicare-approved amount as payment in full. If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more – up to 15% over Medicare's approved amount for services.

If You Are Not Eligible For Medicare

Retiree Montefiore Provider Network

The Medical Center encourages you to use Montefiore providers and facilities by offering the following services – *free of charge* – for you and your covered family members:

- ***Physicians and Therapists*** – A Montefiore Medical Group Primary Care Physician (PCP) at a Medical Group facility
- ***Hospitals and Other Facilities*** – Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, White Plains Hospital, Burke Rehabilitation Hospital, Montefiore Mt. Vernon Hospital, Montefiore Ambulatory Surgical Facilities, Schaffer Extended Care Center, Montefiore Imaging Center and Montefiore Department of Radiology, Advanced Endoscopy Center and NY GI Center
- ***Laboratories*** – Quest Laboratories, LabCorp and all Montefiore laboratories.

A listing of these physicians is listed on the Empire BlueCross BlueShield Website **www.empireblue.com/montefiore** or you can call the Empire Customer Service Call Center at **866.236.6748**.

Empire Provider Network

If you are not yet eligible for Medicare, you can save money on certain healthcare expenses by using the Empire Provider Network. Montefiore has contracted with Empire for access to its network of physicians, hospitals and other healthcare providers. You can visit any physician in the Empire Indemnity Network, Empire Behavioral Health Network and Montefiore Integrated Provider Association (MIPA) in any specialty without a referral.

Empire Network 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 (subject to any deductible and coinsurance). It does not affect the cost-sharing percentages established by the Plan. For example, if you visit a physician who participates in the Empire Indemnity Network, the Plan pays 80% and you are responsible for 20% of the discounted rate. You are not required to use these providers. However, if you or a covered dependent is under age 65, you may save money if you do.

MIPA physicians are listed on the Empire Website **www.empireblue.com/montefiore/MIPA Directory** or you can contact Montefiore CMO Customer Service Department at **914.377.4400**.

To find an Empire Indemnity Network or Empire Behavioral Health Network provider, you can call the Empire customer service call center at **866.236.674**8 or go to **www.empireblue.com/montefiore/Find A Doctor**.

The Deductible

The deductible is the dollar amount that you must pay toward before benefits for certain covered services begin. The deductible is $100 and applies to you and each covered family member once each calendar year.

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.
- In the calendar year you retire, any amounts used to satisfy the deductible under your active medical coverage will be applied toward the retiree annual medical deductible.

Annual Out-of-pocket Maximum

Once a participant has paid $2,000 out-of-pocket for covered medical expenses – plus the medical deductible – in a calendar year, the Montefiore Medical Center Retiree Health Plan will pay 100% of any remaining eligible expenses that individual incurs for the rest of that calendar year. The $2,000 limit does not include copayments for prescription drugs or amounts you pay for outpatient mental healthcare. Services and supplies that are excluded or expenses for services that exceed annual or lifetime limits are not eligible for 100% reimbursement once the annual out-of-pocket maximum has been reached. You must pay these expenses on your own, as well as any charges that exceed reasonable and customary limits.

Covered Expenses

Only expenses specifically listed in this SPD are covered. The services must be medically necessary for the treatment or diagnosis of a covered condition and legal in the state in which they are obtained. All other expenses are excluded.

In-hospital Care

Retiree Medical benefits pay 100% of semi-private hospital room, board and medical supplies for up to 365 days for each separate admission. If only private rooms are available, medical coverage reimburses those charges up to the prevailing semi-private room rate in the geographic 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 Mental Health/Substance Abuse Care

Retiree Medical coverage pays 100% of the cost for inpatient mental health/substance abuse care – in either a general hospital or special treatment facility.

For purposes of this benefit, a special treatment facility means the following:

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

Alternatives to In-hospital Care

Retiree Medical benefits pay 100% for the following facilities and services:

- Ambulatory Surgical Facility
- Birthing Center – for expenses that would have been covered had they been performed in a hospital
- Home Healthcare – for up to 200 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. Covered home healthcare expenses include:
  - Ambulance or ambulette to the hospital for needed care
  - Home infusion therapy
  - Medical social worker visits
  - Medical supplies, drugs and medicines prescribed by a physician
  - Necessary laboratory services
  - Part-time home health aide services
  - Part-time professional nursing
  - Physical, occupational or speech therapy
  - X-ray and EKG services.
- Hospice – medical care and treatment of a terminally ill patient for up to 210 days – provided the care is not primarily custodial. The care must be recommended by a physician and provided at any licensed facility or at home.
- Skilled Nursing Facility – up to 120 days each calendar year.

Medical/Surgical

This part of your Retiree Medical coverage is designed to pay the major share of the cost of a wide range of Medical/Surgical services and supplies.

COVERED EXPENSES

Medical/Surgical pays 100% of covered services with an MMG primary care physician; otherwise 80% after the deductible – up to reasonable and customary limits – for the following services:

- Artificial insemination
- 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
- Allergy testing and treatment
- Ambulance service – in a medical emergency to the nearest medical facility equipped to treat that condition, or if medically necessary
- Artificial limbs and eyes – and their replacement if required because of a change in the patient's physical condition
- Assistant surgeons' fees (if medically necessary)
- Birth control – IUDs, diaphragm fittings, Norplant
- Blood, blood plasma or blood derivatives – plus equipment to administer it
- Cardiac Rehabilitation
- Chemotherapy
- Consultations and Surgical Opinions – second and, if needed, third opinions
- Dental services – only for extractions of impacted teeth and treatment of an accidental injury to sound, natural teeth within 12 months of the date of injury
- Eyeglasses or contact lenses (initial pair) – including the cost of the examination and fitting, if required because of the loss of the eye's natural lens through surgery – i.e., cataracts
- Foot care – routine care for up to eight visits in a calendar year
- Gynecological exams (routine) (100% with MMG primary care physician; otherwise 80% after the deductible)
- Hearing aid – one per lifetime
- Immunizations – Hepatitis A, annual flu shot, tetanus, Pneumococcal

- Mammography (routine)
- Medical equipment – rental or purchase
- Mental healthcare
- Obstetrical (maternity) care – including termination of a pregnancy
- Occupational therapy and supplies
- Orthopedic and prosthetic devices – initial fitting, later adjustment and replacement, if required because of a change in the patient's condition
- Orthotics – orthopedic or corrective shoes and other supportive appliances of the feet
- Outpatient diagnostic and laboratory tests – including MRI, MRA, PET, CAT Scans, Nuclear Cardiology, bone density tests, X-rays, blood, urine and other laboratory tests (100% at Quest Laboratories, Moses, Wakefield or Weiler/Einstein Laboratories; otherwise 80% after the deductible)
- Oxygen and the rental of equipment to administer it
- PAP test (routine)
- Physical exam (routine) – once in a calendar year in conjunction with an office visit (100% with MMG primary care physician; otherwise 80% after the deductible)
- Physical therapy – if active treatment to improve an individual's condition and provided by a licensed therapist under the direct supervision of a physician
- Physicians' services – services of physicians, surgeons and other specialists for surgical and non-surgical services in the hospital, home or office (100% with MMG primary care physician; otherwise 80% after the deductible)
- Pre-admission tests – if performed within 14 days of a scheduled hospital admission
- Radiologists' fees for reading X-rays
- Radiation therapy
- Reconstructive surgery following a mastectomy – while the person is covered by retiree medical benefits including:
  - Reconstruction of the breast on which the mastectomy was performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses
  - Treatment of physical complications at all stages of the mastectomy, including lymphedema

- Sleep disorders – treatment of sleep apnea and narcolepsy
- Speech therapy – but only to restore normal speech lost because of an illness, injury or surgical procedure while covered under Retiree Medical benefits (if provided by a qualified therapist)
- Substance abuse care
- Surgical opinions – second and, if needed, third opinions
- Surgical treatment required because of morbid obesity (limited to one procedure in a lifetime)
- Syringe and testing strips
- Ultrasound and amniocentesis
- Vision therapy
- Voluntary sterilization – (but not reversals)
- Well child care – up to a maximum of 11 visits until the age of two (100% with MMG primary care physician; otherwise 80% after the deductible)
- Well woman care (100% with MMG primary care physician; otherwise 80% after the deductible)
  - Screening for gestational diabetes
  - HPV testing
  - Contraceptive methods and counseling
  - Breast feeding support, supplies and counseling
  - Counseling for sexually transmitted infections
  - Counseling and screening for HIV
  - Screening and counseling for interpersonal and domestic violence
- Wigs and hairpieces – only after chemotherapy and/or radiation therapy; limited to one per illness.

Prescription Drug Benefits

If you are Not Eligible for Medicare

Montefiore's Retiree Prescription Drug coverage permits you to purchase:

- Up to a 90-day supply of each prescribed Montefiore pharmacy formulary drug at Montefiore 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 copayment for each prescription 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 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 reasonable and customary cost of the prescription.
- Up to a 90-day supply of each prescription drug through the home delivery pharmacy service subject to copayment for each prescription. Additional information is available from Express Scripts at **800.631.7780** or online at **www.express-scripts.com**

PRESCRIPTION DRUG OVERVIEW

If You Use	Your Cost If You Purchase: Generic	Preferred Brand Name	Non-preferred Brand Name	Specialty
Montefiore Outpatient Pharmacy				
· 30-day supply · 90-day supply	$0	$0	$0	$0
Express Scripts				
Participating Retail Pharmacy[1]				
· 31-day supply	25% coinsurance $5 minimum $150 maximum	25% coinsurance $15 minimum $150 maximum	25% coinsurance $30 minimum $150 maximum	25% coinsurance $15 minimum $150 maximum
· 60-day supply	25% coinsurance $10 minimum $300 maximum	25% coinsurance $30 minimum $300 maximum	25% coinsurance $60 minimum $300 maximum	25% coinsurance $30 minimum $300 maximum
· 90-day supply	25% coinsurance $15 minimum $450 maximum	25% coinsurance $45 minimum $450 maximum	25% coinsurance $90 minimum $450 maximum	25% coinsurance $45 minimum $450 maximum
Home Delivery Pharmacy Service	You pay the following copays:			
· 30-day supply	$5 copay	$15 copay	$30 copay	$15 copay
· 90-day supply	$10 copay	$25 copay	$40 copay	$25 copay

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

Retiree Medical includes a separate out-of-pocket maximum for prescription drugs. Your share of copayments for prescriptions obtained at an Express Scripts participating pharmacy or Home Delivery Pharmacy Service is limited to $1,500 for any one covered person in a calendar year. Once that maximum is reached, the Plan pays 100% of any remaining retail prescription drug expenses for that individual for the rest of the calendar year.

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.

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 REVIEW

Utilization management reviews strengthen the quality and safety of the Express Scripts Prescription Drug Program.

- ***Drug Utilization Review*** – Express Scripts reviews your prescriptions and will alert your physicians and pharmacists for situations that indicate: drug interactions, allergies or disease; excessive daily dosing or duration of therapy; gender contraindications; potential drug name confusion; refills too-late or too-soon; severe drug interactions; sub-therapeutic dosing or therapy duplication.
- ***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.
- ***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*** – If you doctor prescribes a drug that requires prior authorization, Express Scripts will review your prescription and contact your doctor to determine if your prescription qualifies for drug coverage based on nationally accepted clinical guidelines and standards.

If You are Medicare-Eligible

If you are eligible for Medicare, **Express Scripts Medicare**™ (PDP) **for Montefiore Medical Center** – combines Retiree Prescription Drug coverage with the benefits available through an employer-provided Medicare Part D Plan. This combined benefits coverage means that you will have **more coverage than the standard Medicare Part D Plan**.

Automatic Enrollment

If you are Pre-Medicare:	**If you are Medicare-Eligible:**
You will be covered by Montefiore's Retiree Prescription Drug benefits.	Montefiore will enroll you in Medicare Part D[1]. You will get an individual ID card from Express Scripts Medicare.
If an eligible family member is Pre-Medicare:	**If an eligible family member is Medicare-Eligible:**
Your family member will be covered by Montefiore's Retiree Prescription Drug benefits.	Montefiore will enroll your family member in Medicare Part D[1]. Your family member will get an individual ID card from Express Scripts Medicare.
[1] You may be contacted if we need information in order to enroll you in the plan, such as your Medicare Health Insurance Claim Number (HICN), which can be found on your Medicare Part A ID card.	

How to Opt Out

You are not required to be enrolled in this plan. If you want to waive Express Scripts Medicare™ (PDP) for Montefiore Medical Center coverage, complete a Medicare Part D Coverage Waiver Form and return it to the HR-Benefits Office.

However, please carefully consider your decision to opt out of this plan. If you waive coverage, you will lose both your Retiree Medical and Prescription Drug coverage from Montefiore Medical Center and will not be allowed to re-enroll at any point in the future. Your covered spouse/domestic partner and children will also lose their medical and prescription drug coverage.

Keep in mind that if you opt out of this plan and don't have or get other Medicare prescription drug coverage or creditable coverage that is at least as good as Medicare's standard plan; you may be required to pay a late enrollment penalty (LEP). This happens when you enroll in a Medicare prescription drug plan after going 63 consecutive days or longer without Medicare Part D coverage or other creditable prescription drug coverage.

Network Pharmacies

You have access to in-network pharmacies available under Montefiore's Retiree Prescription Drug coverage. In addition, Duane Reade and Walgreen pharmacies are network pharmacies for Express Scripts Medicare and you will be able to use those pharmacies to fill your prescriptions.

> **Note:** Medicare only covers drugs filled at network pharmacies. However, due to the additional coverage provided by Montefiore, you may use an out-of-network pharmacy. You pay the full amount of the prescription and send a request for reimbursement with your receipt to Express Scripts Medicare. You will be reimbursed the same as you would under the current prescription drug plan – 75% of the reasonable and customary cost of the drug.

Enrollment in Multiple Medicare Prescription Drug Plans

You may only be enrolled in *one* Medicare Prescription Drug Plan. If you are already enrolled in another Medicare Part D plan or in a Medicare Advantage plan with or without prescription drug coverage, you will automatically be dis-enrolled from that plan when you are enrolled in Express Scripts Medicare for Montefiore Medical Center.

Likewise, if, in the future, you enroll in another Medicare Part D plan or in a Medicare Advantage plan, you will automatically be dis-enrolled from Express Scripts Medicare for Montefiore Medical Center.

Note: If you are dis-enrolled from Express Scripts Medicare, you will lose both your Montefiore-sponsored medical and prescription drug coverage and will not be able to reenroll in the plan at a later time. If you are the retiree, your covered family members will also lose both their Montefiore-sponsored medical and prescription drug coverage.

Prescriptions filled at Veterans Affairs (VA) pharmacies are ***not*** covered by the plan. You may receive benefits from only one government program at a time. You may use either your VA benefits at a VA pharmacy or the Medicare Part D benefit through Express Scripts Medicare.

Different Formulary

Medicare Part D's formulary (the list of drugs it covers) may be different from those covered under Montefiore's formulary. However, because of the combined benefits, you are covered under both formularies.

Extra Help – If You Need It

If you have limited income – less than $17,820 for an individual or $24,030 for married filing jointly – you may qualify for Medicare prescription drug coverage Extra Help. Extra Help may pay some or all of your costs, including your monthly premiums annual deductibles and prescription copayments related to a Medicare prescription drug plan.

You will be notified if Medicare identifies you as an individual that qualifies for Extra Help. You may also apply online at **www.socialsecurity.gov/extrahelp** or call Social Security at **800.772.1213**
(TTY 800.325.0778).

If you qualify for Extra Help and contribute toward the cost of your Montefiore-sponsored retiree medical and Express Scripts Medicare prescription drug coverage, Montefiore will reimburse you for the amount that would be covered by Extra Help. For more information, contact HR-Benefits at **montebenefits@montefiore.org** or call **914.349.8531**.

High Income Additional Premium

If your retirement income is more than $85,000 for an individual or $214,000 for married filing jointly, Medicare requires that you pay an additional premium, called the Part D Income-Related Monthly Adjustment Amount (D-IRMAA). Medicare Part D beneficiaries affected by IRMAA will be notified by Social Security.

The additional premium ranges from $13.30 to $76.20 per month in 2017, depending on your income. The IRMAA contribution will be automatically deducted from your Social Security benefits. If your Social Security benefit is not enough, Medicare will bill you directly.

If you are billed directly, you *must* pay this additional amount. If you don't, Medicare will dis-enroll you from Express Scripts Medicare for Montefiore Medical Center. If you are dis-enrolled from the plan, you will lose both your Montefiore-sponsored retiree medical and Express Scripts Medicare prescription drug coverage.

Medication Therapy Management (MTM)

Medicare requires Medicare prescription drug plans to offer an optional, free service called Medication Therapy Management (MTM). If you take multiple medications, have a chronic condition or high drug costs, you may be invited to participate in a MTM program designed for your specific health issue. You may choose not to participate, but you should carefully consider taking advantage of this free service.

If you take many medications for more than one chronic health condition, contact Express Scripts Medicare Customer Service at **866.544.6963**, to see if you're eligible for a Medication Therapy Management program.

Important Notice for Medicare-eligible Individuals About Montefiore 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 Medical Center 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:

- **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.**
- **Montefiore Medical Center has determined that the prescription drug coverage offered by the 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 November 15th through December 31st.

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?

Your Montefiore medical options pay for other health expenses, in addition to prescription drugs. If you choose to enroll in a Medicare prescription drug plan, you will ***not*** be eligible to receive Montefiore health and prescription drug benefits.

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 Medical Center 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 November 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. You can also get more information about Medicare prescription drug plans from the following resources:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA) at **www.socialsecurity.gov**, or call **800.772.1213 (TTY 800.325.0778)**.

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

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

Maximum Benefits

The Montefiore Medical Center Retiree Health Plan provides $500,000 in maximum lifetime benefits for you and each covered family member, exclusive of hospital, Medco prescription drug and dental benefits. 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
- Foot care – routine care for up to eight visits in a calendar year
- Hearing aid – one per lifetime
- Home healthcare – up to 200 visits each calendar year
- Hospice care – for up to 210 days
- Mammography (routine) – one prior to age 40; one a year at age 40 or older
- PAP tests – once in a calendar year in conjunction with an annual physical or gynecological examination
- Physical exams (routine) – once in a calendar year
- Skilled Nursing Facility – for up to 120 days each calendar year
- Surgical treatment required because of morbid obesity – limited to one procedure in a lifetime
- Wigs and hairpieces – for hair loss resulting from chemotherapy and radiation therapy; limited to one wig per illness.

Exclusions

Retiree Medical coverage does not pay benefits for all medical services and supplies, even if recommended by a physician. Expenses not covered include:

- Acupuncture – for anesthetic purposes in conjunction with surgery
- Chiropractic services
- 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
- 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 Retiree 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)
- Nutritionists

- 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 care
- 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 Retiree 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
  - Provided outside the United States or its territories, except for an accidental injury or medical emergency
  - **Which are not specifically listed as covered expenses in this Summary Plan Description (SPD)**
  - 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.

Coverage Under Two or More Plans

If you or a family member is covered by more than one group medical plan, including Medicare, payment of benefits depends on whether you are covered by Basic Retiree Medical (Option 1) or Basic Retiree Medical *Plus* Supplement (Option 2).

Basic Retiree Medical – Option 1

Option 1 contains a non-duplication of benefits feature. The non-duplication of benefits provision limits the combined payments from all plans, including Medicare, to no more than Option 1 would pay if there had been no other coverage.

If Option 1 pays benefits second, it will not duplicate any benefits that have already been paid. This means that if the other plan pays benefits that are equal to or more than Option 1 benefits, no payments will be made from the Montefiore Medical Center Retiree Health Plan.

When you or a covered dependent becomes eligible for Medicare (generally at age 65), Option 1 continues to cover – and exclude – all the same expenses described earlier. If Medicare benefits are equal to or more than Option 1 benefits, no payments will be made from Option 1. Option 1 will not pay charges that are denied by Medicare as a result of your failure to comply with any Medicare restrictions and requirements.

Basic Retiree Medical Plus Supplement – Option 2

Option 2 contains a coordination of benefits provision which limits combined benefits from all plans and any other payment sources to 100% of covered expenses. This means that once Medicare has made its payment, Option 2 will reimburse any remaining eligible charges that Medicare does not pay. However, Option 2 will not pay charges that are denied by Medicare as a result of your failure to comply with any Medicare restrictions and requirements.

Non-duplication and coordination of benefits provisions apply to Medicare, Champus/Tricare and any other government programs with which the Montefiore Medical Center Retiree Health Plan is allowed to coordinate by law. These provisions do not apply to any personal policy – except no-fault automobile insurance, Medicaid or any other government programs with which the Montefiore Medical Center Retiree Health Plan is not allowed to coordinate by law.

DETERMINING WHICH PLAN PAYS BENEFITS FIRST

How much either Medical option pays is determined by which plan is primary. The primary plan pays benefits first. The following guidelines are used to determine which plan is primary.

- The plan that does not have a non-duplication provision or coordination of benefits provision is primary.
- When both plans have a non-duplication or coordination of benefits provision:
  - The plan covering the person as an employee is primary and will pay benefits up to the limits of that plan; the plan covering the person as a dependent, retiree or COBRA participant (terminated employee who elected COBRA coverage) is secondary and pays any remaining eligible costs.
  - The plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay children's benefits first; the plan covering the other parent pays second and pays the remaining costs to the extent of coverage. This is called the "birthday" rule and is currently used by the Retiree Health Plan.
  - In those plans which do not include the "birthday" rule, the father's plan is primary and will pay children's benefits first; the mother's plan pays second. This is called the "male-female" rule.
  - If one parent is covered by the "male-female" rule and the other by the "birthday" rule, the "male-female" rule applies.
  - If the parents of a dependent child are divorced or legally separated, the claims administrator will determine if there is a court decree which establishes financial responsibility for medical and dental care. If there is such a decree, the plan covering the parent who has that responsibility will be primary and pays first.
  - If there is no decree, the plan which covers the child as a dependent of the parent with custody is primary and pays first; the other parent's plan is secondary.
  - If there is no decree and the parent with custody remarries, that parent's plan remains primary; the stepparent's plan is secondary; the non-custodial parent's plan is third.
- If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan and pays first.

If you or your covered dependent is Medicare-eligible, the Medicare plan in which you are enrolled is generally primary. Medicare is secondary for the 30-month period beginning with the month in which a participant first becomes entitled to Medicare benefits due to end stage renal disease.

When Medicare is primary and pays first:

- The plan covering the patient as a retiree is secondary to Medicare
- The plan covering the patient as a dependent pays benefits third.

If a patient is *not* eligible for Medicare:

- The plan covering the patient as a retiree (or associate) is primary
- The plan covering the patient as a dependent pays benefits second.

In Case of a Retiree's Death

For the first year following a retiree's death, Montefiore will pay the full cost of Retiree Medical coverage for the surviving spouse or qualified domestic partner and any enrolled dependent children. At the end of the one-year period, surviving dependents can continue coverage by paying the full cost in effect at that time, as determined by Montefiore Medical Center.

Your Retiree Dental Benefits

You have a one-time opportunity when you retire from Montefiore to elect contributory Retiree Dental coverage for you and your eligible family members. Retiree Dental provides coverage for:

- Preventive and diagnostic services

  and

- Basic and major services after an individual annual deductible.

If you elect Retiree Dental, you can stop coverage at any time. Keep in mind, however, that an election to waive or stop Retiree Dental coverage is irrevocable. You will not be able to elect Montefiore Retiree Dental coverage in the future.

Cigna Reimbursement Levels

In-network Benefits

Preventive & Diagnostic Dental Care, Cigna DPPO Dental Plan and Cigna DPPO Enhanced Dental Plan reimbursement levels are based on contracted fees with providers in the Total Cigna Network, which includes the Montefiore Department of Dentistry. 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. Go to **www.cigna.com** for a list of participating dentists or contact Customer Service at 800.Cigna24 (800.244.6224).

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 you must pay toward basic and major services before Retiree Dental coverage starts paying benefits for certain expenses. The deductible is $100 and applies to each covered individual once each calendar year.

In the calendar year you retire:

- Any amounts used to satisfy the deductible under active dental coverage will be applied toward your Retiree Dental deductible

  and

- Any benefits paid under active dental coverage will apply to any annual or lifetime limits under Retiree Dental coverage.

For example, assume that you retire on May 31st and had paid $75 toward the active dental deductible. In July, you need further dental work. The $75 applied toward the deductible under the active dental option will be applied to the Retiree Dental deductible. So, you need only pay another $25 in covered expenses to meet the Retiree Dental annual 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**.

- **Cigna Retiree Dental Benefits Summary**

Preventive & Diagnostic Care · Oral Exams, Cleanings · Fluoride Application · Sealants (Limited to posterior tooth) · Space Maintainers (limited to non-orthodontic treatment) · X-Rays – Bitewings (routine) – Full mouth (non-routine) – Panorex (non-routine)	100%, No Deductible
Basic Restorative Care · Fillings · Oral Surgery - simple extractions, except surgical extraction of impacted teeth, anesthetics · Periodontics – various limitations depending on the service · Root Canal Therapy/Endodontics Relines, · Brush Biopsy · Stainless Steel/Resin Crowns · Emergency Care to Relieve Pain · Anesthetics	80%, After Deductible
Major Restorative Care · Crowns/Inlays/Onlays · Dentures, Bridges · Relines, Rebases, and Adjustments · Repairs - Bridges, Dentures	50%, After Deductible
Orthodontia	Not covered
[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

Pre-treatment review lets you know in advance how much you will be reimbursed when extensive dental work is expected. Whenever your dentist estimates that his or her services will exceed $200, you can have your dentist submit a proposed course of treatment to the Claims Administrator before the work begins.

Although a pre-treatment review is not required, it is helpful 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, the Claims Administrator will base its payment on the least costly procedure that is consistent with good dental care. Using pre-treatment review can help avoid a misunderstanding about what covered expenses will be reimbursed and what portion of the cost you will be required to pay.

Maximum Benefits

You and each covered family member can receive up to $1,200 in benefits each calendar year for preventive and diagnostic, basic and major services combined. Some covered services are subject to separate limits and/or annual maximum benefits. These limits and maximums apply to each covered individual and are:

- Preventive & Diagnostic Services
  - Oral Exams – 2x/calendar year
  - Cleanings – 2x/calendar year
  - Routine X-Rays – Bitewings 2x/calendar year
  - Fluoride Application – 1x/calendar year up to age 19
  - Sealants – Limited to posterior tooth. One treatment per tooth/three years up to age 19
  - Space Maintainers (limited to non-orthodontic treatment)
  - Non-Routine – X-Rays
    - Full mouth: 1x/3 calendar years
    - Panorex: 1x/3 calendar years
- Major Restorative Services
  - Crowns/Inlays/Onlays – Replacement every 5 years
  - Dentures – Replacement every 5 years
  - Bridges – Replacement every 5 years
  - Relines, Rebases, and Adjustments – Covered if more than 6 months after installation
  - Repairs – Bridges, Crowns, Dentures, and Inlays –Reviewed if more than once
  - Prosthesis Over Implants –1x/5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Exclusions

Retiree Dental coverage does not pay for all dental services and supplies – even if recommended by a dentist. Expenses ***not*** covered include:

- Appliances to correct harmful habits or to stabilize periodontally involved teeth
- Athletic mouth guards
- Charges for broken appointments
- Conditions caused by the commission of or participation in a crime, riot or war (declared or not) or incurred while serving in the armed forces; injuries sustained by the victim of a crime or riot are covered provided the individual is not in the military
- 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
  - For services performed after Retiree Dental coverage ends, except for the following services if performed within the next 30 days:
    - Installation or adjustment of dentures or fixed bridgework, if the impression was taken while coverage was still in effect
    - Restoration of a crown, inlay or onlay, if the tooth or teeth were prepared before coverage ended
    - Root canal therapy, if the pulp chamber was opened before coverage ended
  - **In excess of reasonable and customary limits**
  - Incurred before you or one of your family members became a Retiree Dental participant
  - Incurred outside the United States or its territories except in a dental emergency
- Extractions of impacted wisdom teeth and other teeth impacted in bone
- 50% of the benefit otherwise payable for dentures or bridgework for teeth lost or extracted before Montefiore dental coverage begins (full coverage is provided once the person has been an active and/or Retiree Dental participant for at least 24 consecutive months)
- Hospital charges
- Illness or injury – treatment of occupational illness or injury

- Mailing or shipping expenses
- Myofunctional therapy
- Orthodontia
- Periodontal splinting
- Personalization or characterization of prosthetic devices
- Plastic, reconstructive or cosmetic surgery – or other treatment – solely to improve, alter or enhance appearance unless needed to repair an injury and provided surgery is performed no later than the calendar year following the accident that caused the injury
- Prescription drugs
- 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 Retiree 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 a Health Maintenance Organization or Dental Maintenance Organization
  - 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 not specifically listed as covered expenses in this Summary Plan Description
  - Which are primarily experimental/investigational in nature
- Treatment of jaw joint disorders including temporomandibular joint dysfunction (TMJ)
- Veneers or facings on molar crowns and pontics.

Coordination of Benefits

Retiree Dental coverage contains a coordination of benefits (COB) feature which applies if you or your family members are covered by two or more group dental plans. The dental COB works the same way as it does for the Basic Retiree Medical *Plus* Supplement (Option 2). This feature limits combined benefits from all group dental plans or any other source of payment to 100% of covered expenses.

In Case of a Retiree's Death

Following a retiree's death, surviving family members enrolled for Retiree Dental can continue coverage by paying the full cost in effect at that time, as determined by Montefiore.

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.

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

Generally, hospitals submit their bills directly to the Claims Administrator – or directly to Medicare if you are covered by that government program or a Medicare option. If you do receive a hospital bill do not pay it. Make sure it is itemized and forward it to Medicare or the Medicare plan in which you are enrolled – otherwise to the Claims Administrator.

Laboratory Benefits

If you receive a bill from Montefiore LabCorp or Quest Laboratories for outpatient diagnostic and laboratory tests do not pay it. Call the billing department, identify yourself as a Montefiore Retiree and instruct them to send the invoice to Medicare or the Claims Administrator.

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 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 healthcare provider complete his or her portion too. 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 provided with an itemized description of each charge
- The diagnosis and CPT 4 code, if applicable
- The date(s) of service
- The patient's name
- The provider's name, address, phone number and degree
- The provider's federal tax identification number

  and

- If you are eligible for Medicare, a copy of your Medicare (or Medicare option's) "Explanation of Benefits," showing the benefits paid by that plan. If you do not do so, an estimate of what Medicare or the Medicare plan would have paid will be deducted from your Retiree Medical benefit.

Prescription Drugs

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

Claims Administration

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

To claim benefits for these covered expenses:	**Claims should be submitted as follows:**
Healthcare Expenses · If you are Medicare-eligible	Medicare
· Medical	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 **866.236.6748**
· Dental	Cigna Healthcare P.O. Box 188037 Chattanooga, TN 37422-8037 **800.Cigna24 (800.244.6224)**
Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 **800.631.7780**
All claims must be submitted by the end of the calendar year following the year the expense was incurred. Otherwise, no benefits will be paid.	

You must include the name and ID Number of the Montefiore Retiree on *all* claim forms submitted to the Claims Administrator – including claim forms provided to you by your physician or dentist and claims for covered expenses incurred by a covered dependent. If you do not provide the Montefiore Retiree's name and ID Number on each claim form, 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.

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.

Continuation Coverage (COBRA)

If Montefiore Medical Center Retiree Health Plan coverage stops as a result of a "qualifying event" listed below, you and/or your eligible family members can elect continuation coverage under the Retiree Health Plan coverage you had in effect at the time of the qualifying event.

The following table identifies "qualifying events" and the length of time you may elect to continue coverage.

If you are:	**And lose healthcare coverage due to one of the "qualifying events" shown below:**	**You can choose continuation coverage for up to:**
A covered spouse of a retired MMC associate	· Divorce, legal separation or annulment · Death of retired associate	36 months
A covered dependent child of a retired MMC associate	· Your parents' divorce, legal separation or annulment · Death of retired associate · You no longer meet the Plan's definition of dependent	36 months
If coverage terminates because MMC files for reorganization under Title 11 of the United States Code, or coverage is substantially eliminated during a period beginning one year before and ending one year after a reorganization, it can be continued for: · The lifetime of a covered retiree or surviving spouse at the time of bankruptcy · 36 months after the death of the retired associate for a dependent child or for a covered spouse who is not a surviving spouse at the time of the filing for reorganization.		

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 the 18-month coverage period for medical coverage is extended to 29 months as a result of disability, the premium- for the disabled family member will increase to 150% of the cost of coverage for the additional months.

You or your family members must notify the HR-Benefits Office in writing if healthcare 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:

- The date you receive notice of your right to continue healthcare coverage

  or

- The date healthcare coverage stops, if later.

If you or a dependent initially waive 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 become eligible provided you pay the full required retroactive contributions on a timely basis.

You have 45 days after you elect COBRA continuation 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 premiums no later than the first day of each 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.

When the continuation period ends, healthcare benefits stop.

Continuation coverage may be cut short if:

- You or your family members do not make all the required continuations on a timely basis
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition

  or

- Montefiore terminates all retiree 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, Inc.
COBRA Administration
P.O. Box 14055
Lexington, KY 40512-4055
877.502.6272

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.

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 Healthcare.

- **Access to Medical Records** – HIPAA gives you the ability to review and obtain copies of your medical records. If your medical records are maintained electronically, you may request access to your electronic medical records, if that format is readily producible. Otherwise, the covered provider must provide the requested information in an electronic format that you can read on your computer (e.g., Word, Excel, etc.). You may also request corrections if you have identified any errors. Covered providers generally should provide access to your records within 30 days of your request and may charge for the cost of copying and sending the records to you.
- **Notice of Privacy Practices** – Covered providers will provide you with a HIPAA notice advising you of your rights. You may be asked to sign, initial or otherwise acknowledge that you have received this notice. You may also ask to restrict the use or disclosure of your information beyond the practices included in the notice, but the covered providers would not have to agree to the changes. Individuals who pay their providers by cash can instruct their provider not to share information about their treatment with their health plan.
- **Confidential Communications** – Under the privacy rule, you can request that your doctors, health plans and other covered providers take reasonable steps to ensure that their communications with you are confidential. For example, you could ask your doctor to call you at work rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.
- **Stronger State Laws** – The federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; any state law providing additional protections would continue to apply. When a state law requires a certain disclosure – such as reporting an infectious disease outbreak to the public health authorities – the federal privacy regulations would not preempt the state law.

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

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

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

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

Genetic Information Non-discrimination Act of 2008 (GINA)

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

Surcharge

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

It is important for you not to make this payment since Montefiore has already made this payment for you. Neither Medicare nor the Claims Administrator will reimburse you for this charge. If you have paid this surcharge, you should contact the provider for a refund. You can ask the Claims Administrator to send a letter to the provider confirming that the Claims Administrator has paid the surcharge to the State.

Subrogation

The Plan does not cover expenses for services or supplies which a third party is required to pay because of a negligent or wrongful act. However, the Plan will advance payment on account of Plan benefits.

This provision applies if you and/or your covered dependent(s) 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 Retiree Health Plan from whatever moneys are recovered from the third party (whether an individual or insurance company is liable) as a result of a court judgment, settlement or otherwise. Here is an example of how subrogation works.

If you were hurt as a result of another person's negligence, the individual – or his or her insurance company – might compensate you for your injury. In that case, you would be required to repay any amounts the Plan had advanced to you and/or your covered dependents for medical 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

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 Retiree Medical Plan is required to pay benefits directly to the child, the child's parent or legal guardian, according to the order. However, the child must be enrolled and the associate must be making any required contributions. For further information, contact Montefiore's HR-Benefits Office.

Termination of Coverage

Montefiore Medical Center Retiree Health Plan coverage stops on the date:

- The Plan is terminated
- Montefiore withdraws from participation in the plan

  or

- You stop making any required contributions.

If your coverage stops, your family members' coverage stops too. If a dependent no longer qualifies as an eligible family member, healthcare coverage ends on the last day of the calendar year.

Retiree Life Insurance

Retiree Life Insurance is provided through the Montefiore Medical Center Insured Benefit Plan. It is designed to pay a life insurance benefit to your beneficiary if you die while coverage is in effect.

What the Life Insurance Section Includes

Glossary of Key Terms

Beneficiary – The person or persons you name to receive your Retiree Life Insurance benefits. You may name anyone as your beneficiary and can change your choice at any time and for any reason. Your primary beneficiary is the individual who will receive your Retiree Life Insurance benefit if you die. Your contingent beneficiary receives your Retiree Life Insurance benefit in the event your primary beneficiary dies before receiving benefits. If you name more than one primary or contingent beneficiary, they will share the benefit equally, unless you designate otherwise.

Plan Benefits

The amount of life insurance that continues during retirement depends on whether you retire at 65 or older, or before age 65.

If you retire:	**This amount of life insurance continues during retirement:**
At age 65 or older	· 50% of your life insurance coverage in effect on the day before you retire *or* · $25,000 . . . whichever is less – but in no case less than $5,000. On each subsequent January 1, your life insurance is reduced by 10% of the coverage you received when you retired – subject to a minimum benefit of $5,000.
Before age 65	$2,000 without reduction

Payment of Benefits

The full amount of your Retiree Life Insurance is paid to your named beneficiary if you die from any cause. Payment can be made in a lump sum or installments – whatever arrangement your beneficiary makes with the insurance company.

If you do not have a designated beneficiary at the time of your death, or if your beneficiary dies before you, your insurance will be paid in a lump sum to the survivors listed below, subject to State Insurance Department of New York approval, in the following order of priority:

1. Spouse, if any, otherwise
2. Divided equally among your child(ren), if any, otherwise
3. Divided equally between your parent(s), if any, otherwise
4. Divided equally between your sibling(s), if any, otherwise
5. Your estate, if you have no surviving family members, as indicated above.

Accelerated Benefit

Your Retiree Life Insurance coverage includes an “accelerated benefit.” This feature permits you to request payment of up to 75% of your Retiree Life Insurance ($7,500 maximum payment) if you have a terminal illness with a life expectancy of 12 months or less. The benefit paid to your beneficiary upon your death will be reduced by the full amount of the accelerated benefit you receive.

For example, assume you have $10,000 of Retiree Life Insurance and request and receive an accelerated benefit of $7,500. Following your death, your beneficiary will receive $2,500.

The accelerated benefit you receive is currently not subject to income taxes.

Claiming Benefits

In case of your death, your beneficiary should contact Montefiore’s HR-Benefits Office for help in completing the appropriate forms. All claims must be submitted as soon as reasonably possible, but no later than two years after the insured individual’s death. No benefits can be paid until the forms and necessary proof of loss have been submitted to the insurance company. The insurance company will make all decisions with respect to the payment of benefits.

Other Important Information

Assignment of Life Insurance

Any assignment of your Retiree Life Insurance must be reviewed by the insurance carrier prior to approval. You cannot later revoke the assignment. The person to whom you assign your insurance has the absolute and continuing right to name future beneficiaries. However, the person you named as your beneficiary before assigning the policy will continue as beneficiary unless the person to whom you assign the policy chooses someone else.

You cannot assign ownership of your Retiree Life Insurance to provide collateral for a loan.

If you assigned your life insurance while you were an active associate, your assignment continues to apply during your retirement.

Termination of Coverage

Your Retiree Life Insurance coverage stops if the Retiree Life insurance portion of the Montefiore Medical Center Insured Benefit Plan is terminated for any reason.

Conversion Privilege

If Retiree Life Insurance coverage is reduced or terminated, you can convert all or part of the difference to an individual policy without having to provide evidence of insurability to the insurance company.

To convert your coverage, you must apply for conversion and pay the first premium within 31 days after coverage would otherwise end. The individual policy can be any type of permanent life insurance customarily issued by the insurance company – including term insurance for up to one year, but not including a life insurance policy with disability, accidental death benefits or any other additional benefits.

If you die during the 31-day conversion period – whether or not you had applied for an individual policy – your beneficiary will receive the amount of life insurance you had the right to convert.

If you have assigned your Retiree Life Insurance, the person to whom you have assigned coverage has conversion rights.

ERISA Additional Information

This section contains information about how the Montefiore Medical Center Retiree Health Plan and the Montefiore Medical Center Insured Benefit Plan 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 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 Sponsor

The sponsor of the Montefiore Medical Center Retiree Health Plan and the Montefiore Medical Center Insured Benefit Plan is:

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

Plan Administrator

The Plan Administrator for the Montefiore Medical Center Retiree Health Plan and the Montefiore Medical Center Insured Benefit Plan is:

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

Employer Identification Number

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

Claim Denials and Appeals

You must file a claim to receive benefits under the Montefiore Medical Center Retiree Health Plan and/or Montefiore Medical Center Insured Benefit Plan. 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 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 Plan is shown in the following table.

For These Covered Expenses:	**Claim Denials Are Received from and Appeals Should Be Directed to the Appropriate Fiduciary:**
Medical	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 (866) 236-6748
Dental	Cigna Healthcare P.O. Box 188037 Chattanooga, TN 37422-8037 800.Cigna24 (800.244.6224)
Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 (800) 631-7780
Life Insurance	Principal 711 High Street Des Moines, IA 50392-2840 (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.

Your Right to Appeal

You have the right to appeal a denial of your claim. You must submit a written appeal to the Claims Administrator within 180 days after you receive the claim denial notice. 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 Administrator 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 Administrator 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 claim, the Claims Administrator will notify you of the decision within 30 days after receipt of your appeal.

If your appeal involves a post-service claim, the Claims Administrator will notify you of the decision within 60 days after receipt of your appeal.

If your appeal is denied, in whole or in part, the Claims Administrator 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.”

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 Claims Administrator has the authority to make final decisions with respect to paying claims.

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.

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.

Plan Trustee

Retiree Health Plan benefits are paid by a third party administrator from a trust fund, which is approved under Section 501(c)(9) of the Internal Revenue Code. Life insurance benefits are paid by an insurance company and are not funded through the trust.

The Trustees for the Montefiore Medical Center Retiree Health Plan are:

Senior Vice President and
General Legal Counsel
and
Senior Vice President, Finance
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490
718.920.7602

Administrative Information

Official Plan Name	Claims Administrator/ Insurance Company	Plan Number	Plan Funding
The Montefiore Medical Center Retiree Health Plan			
Hospital and Medical/Surgical benefits	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 **(866) 236-6748**	503	Retiree and Montefiore contributions
Dental benefits	Cigna Healthcare P.O. Box 188037 Chattanooga, TN 37422-8037 **800.Cigna24 (800.244.6224)**	503	Retiree contributions
Prescription Drug coverage	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 **(800) 631-7780**	503	Retiree and Montefiore contributions
The Montefiore Medical Center Insured Benefit Plan			
Life Insurance Benefits	Principal 711 High Street Des Moines, IA 50392-2840 **(800) 245-1522**	508	Montefiore contributions

Plan Type and Plan Year

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

	Plan Type	Plan Year
Medical and Dental	Welfare providing healthcare and dental benefits	January 1 to December 31
Prescription Drug	Welfare providing prescription drug benefits	January 1 to December 31
Life Insurance	Welfare providing life insurance benefits	January 1 to December 31

Plan Documents

This Summary Plan Description (SPD) describes only the highlights of the Montefiore Medical Center Retiree Health Plan and Montefiore Medical Center Insured 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 Plans and which are controlling in the event of a conflict with this SPD. 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 Plan member or beneficiary within 30 days at a nominal cost.

Plan Continuation

Montefiore Medical Center expects and intends to continue the Montefiore Medical Center Retiree Health Plan and Montefiore Medical Center Insured Benefit Plan indefinitely, but reserves the right to change, modify, or terminate the plans through its Board of Trustees, in whole or in part, at any time and for any reason.

If Medical and/or Dental coverage is terminated, you will not have the right to any benefits or have any further rights – other than the payment of covered expenses you had incurred before coverage terminated.

Montefiore does not guarantee the continuation of any benefits at or during retirement, nor do they guarantee any specific level of benefits.

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

The benefits provided by the Montefiore Medical Center Retiree Health Plan and Montefiore Medical Center Insured Benefit Plan 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 or a covered dependent loses coverage under the Montefiore Medical Center Retiree Health 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.

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**.