



Registered Nurses (NYSNA) Program

2015 Summary Plan Description

Introduction

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

This is a Summary Plan Description (SPD) of the plans that make up your Montefiore Registered Nurses Benefits Program. It is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

This SPD provides a description of the Plans in effect on January 1, 2015 including changes which have been collectively bargained between Montefiore Medical Center and the New York State Nurses Association (NYSNA) which became effective January 1, 2011. It explains when you become eligible, what benefits the Plans pay, any benefit limitations that apply, how to file claims and where to obtain additional information.

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

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

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

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If you and/or your dependents are Medicare-eligible, Federal law offers more choices for prescription drug coverage. See page 44 for more details.

Eligibility and Enrollment

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

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Glossary of Key Terms

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

Family Members – Your spouse, if legally married, or qualified domestic partner and children of you, your spouse, or qualified domestic partner whom you can cover through December 31 of the year the child reaches age 26 – or a child who is disabled prior to that age.

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

Montefiore's HR-Benefits Office – Contact the HR-Benefits Office when you need assistance with benefits-related issues, by email at montebenefits@montefiore.org or by calling **914.378.6531**. The mailing address is:

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

NYSNA – The New York State Nurses Association.

Part-time Registered Nurse – An RN who is regularly scheduled to work less than 100% of a full-time schedule whose position is covered by a collective bargaining agreement between Montefiore Medical Center and the New York State Nurses Association if that agreement provides for the coverage described in this Summary Plan Description. A regular part-time RN does not include a contingent or per diem RN. However, to be eligible for the benefits described in this SPD, a part-time RN must be regularly scheduled to work at least 50% of a full-time schedule.

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

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

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

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

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

How the Registered Nurses Benefits Program Works

One of the many advantages of Montefiore's Registered Nurses Benefits Program is the annual reenrollment that takes place each fall. At that time, you will receive all the materials you need to make your elections. The decisions you make during the fall annual election period will take effect the following January 1 and will stay in effect until you make a change during a subsequent fall annual election period (with coverage changing the following January 1) or if you have a qualified change in status.

Your choices for coverage can be made in the following benefit areas. Benefits may be subject to restrictions and limitations. Be sure to read the rest of this SPD for a complete description of available benefits.

YOUR CHOICES	
HEALTHCARE – You make separate elections for medical and dental coverage.	
Medical – Montefiore Health Plan for Registered Nurses <i>or</i> you can elect no coverage.	
➤	<i>Registered Nurses Health Plan</i> – administered by Empire BlueCross BlueShield. Your medical benefits pay for a variety of medical services and supplies in and out of the hospital.
➤	<i>No coverage</i>
Dental – Montefiore Dental Benefits for Registered Nurses, a Dental Maintenance Organization (DMO) <i>or</i> you can elect no coverage.	
➤	<i>Registered Nurses Dental Benefits</i> – comprehensive dental benefits regardless of the dentist you use: <ul style="list-style-type: none"> – 80% for preventive and diagnostic, basic and orthodontic care – after a combined \$25 individual annual deductible – 50% for major services – after a combined \$25 individual annual deductible – Maximum benefits – \$1,300 a person a year; \$1,500 individual lifetime maximum for orthodontics.
➤	<i>Dental Maintenance Organization (DMO)</i> – provides comprehensive coverage with no deductible if you use in-network dentists. <ul style="list-style-type: none"> – 100% for preventive and diagnostic care – 80% (or 100%, depending on the type of expense) for basic care – 80% for major care – 50% for orthodontic care – Maximum annual benefits – none; orthodontic limited to one course of treatment for each eligible person.
➤	<i>No coverage</i>

YOUR CHOICES

FLEXIBLE SPENDING ACCOUNTS

- *Healthcare Account* – Use this account to pay out-of-pocket healthcare expenses you and your eligible family members incur. You can elect not to contribute *or* contribute from \$130 to \$2,000 annually.
- *Dependent Care Account* – Use this account to pay an individual or facility to provide day care for your eligible family members. You can elect not to contribute *or* contribute from \$130 to \$5,000 annually.

GROUP TERM LIFE INSURANCE

- Basic Non-contributory coverage – based on annual earnings; minimum \$10,000 maximum \$60,000
- You can elect Additional Contributory coverage – 25%, 50%, 75% or 100% of your Basic coverage.

Eligibility for Registered Nurse Benefits

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

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

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

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

- Registered nurses whose position is covered by a collective bargaining agreement with 1199
- Associates whose position is covered by the Associates Benefit Program
- Associates whose position is covered by a collective bargaining agreement with 1199 or Local 30
- House Staff Officers
- Leased employees
- Independent contractors
- and*
- Any other associate who is not treated as an employee for payroll purposes even if a court or administrative agency determines that such an individual is an employee rather than an independent contractor.

Family Members

Your family members are also eligible for coverage under the Registered Nurses Benefits Program.

Eligible family members include your spouse or qualified domestic partner and children of you, your spouse, or qualified domestic partner whom you can cover through December 31 of the year they reach age 26.

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

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

Your Cost for Coverage

The following table shows each of the benefit options available to you and whether or not you contribute toward the cost of coverage.

Benefit area	If you are a full-time registered nurse	If you are a part-time registered nurse
Medical ➤ Registered Nurses Health Plan Dental ➤ Registered Nurses Dental Benefits ➤ Dental Maintenance Organization (DMO)	Montefiore pays the full cost; you contribute nothing.	You and Montefiore share the cost of coverage. Your share of the cost is pro-rated based on your schedule as compared to a full-time schedule and the number of hours worked.
Flexible Spending Accounts	You make all the contributions necessary to fund these accounts.	
Life Insurance		
➤ Basic Non-contributory Life Insurance	Montefiore pays the full cost; you contribute nothing.	
➤ Additional Contributory Life Insurance	You pay the full cost of any <i>Additional Contributory Life Insurance</i> coverage you elect. Your cost depends on the amount of coverage you choose and your age. Current contribution rates are available from Montefiore's HR-Benefits Office.	
Accidental Death and Dismemberment (AD&D) Insurance	Montefiore pays the full cost of your AD&D coverage.	
Business Travel Accident (BTA) Insurance	Montefiore pays the entire cost of BTA coverage. You pay nothing.	
Disability Benefits	Montefiore pays the full cost of your Paid Sick Leave, Supplementary Sick Pay, Intermediate-term and Long-term Disability benefits. You make contributions for New York State disability benefits – ½% of your pay up to a maximum contribution of \$1.20 each biweekly pay period – Montefiore pays the rest.	

Making Your Contributions

Any contributions are deducted from your bi-weekly paycheck.

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

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

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

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

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

How to Enroll

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

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

If you have questions about:

- ***The enrollment process or the Enrollment Website***, click on the live Chat icon on the top, right toolbar after you log in (Monday through Friday between 8am and 8pm EST).
- ***Your benefits***, contact the HR-Benefits Office at **914.378.6531** or at montebenefits@montefiore.org.

Enroll Online

Log On To www.montebenefits.com Using Your Username and Password.

➤ **Verify Your Personal Information and Dependent Eligibility.**

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

Important

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

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

➤ **Select Your Benefits.**

- Enroll family members for healthcare coverage.
- You *must* make a Healthcare and/or Dependent Care Flexible Spending Account election each year if you want either or both of these accounts.
- Designate a beneficiary for your Life Insurance.

Dependent Verification

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

- Marriage License or Affidavit of Domestic Partnership (if marriage between same sex partners is not recognized in your legal state of residence)
- Birth Certificate, final Adoption Papers or Court Documents.

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

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

Should you wish to discontinue coverage for a qualified domestic partner, you will need to complete a *Statement Terminating Domestic Partnership*, which you may obtain from and should return to Montefiore's HR-Benefits Office.

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

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

Default Coverage

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

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

If you are a newly eligible part-time registered nurse...

If you are a newly eligible part-time registered nurse and do not enroll within 30 days of the date you first become eligible for benefits, you and your eligible dependents will have no benefits.

HIPAA Special Enrollment Rights

You may request a special health plan enrollment under the following circumstances:

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

When Coverage Begins

For:	This is when coverage begins if you are eligible and are a:	
	A regular full-time or eligible part-time RN	A temporary full-time or eligible part-time RN
Medical, Flexible Spending Accounts	The first day of the month coincident with or after your date of employment provided you have enrolled	The first day of the month coincident with or after you complete three consecutive months of employment provided you have enrolled
Dental	The first day of the month coincident with or after you complete three consecutive months of employment provided you have enrolled	The first day of the month coincident with or after you complete six consecutive months of employment provided you have enrolled
Life and Accidental Death and Dismemberment (AD&D) Insurance	<p>The first day of the month coincident with or after your date of employment for :</p> <ul style="list-style-type: none">▪ Basic Non-contributory Life and AD&D Insurance▪ Additional Contributory Life Insurance, provided you have enrolled within 30 days of the date you first become eligible for benefits	<p>The first day of the month coincident with or after you complete three months of employment for:</p> <ul style="list-style-type: none">▪ Basic Non-contributory Life and AD&D Insurance▪ Additional Contributory Life Insurance, provided you have enrolled within 30 days of the date you first become eligible for benefits
Business Travel Accident (BTA) Insurance	Your first day of employment	
Disability Benefits		
<ul style="list-style-type: none">▪ Paid Sick Leave	The day after you complete 30 days of employment	The day after you complete 90 days of employment
<ul style="list-style-type: none">▪ New York State Disability Benefits	The day after you complete four weeks of employment	
<ul style="list-style-type: none">▪ Supplementary Sick Pay▪ Intermediate-term Disability▪ Long-term Disability	The day after you complete 90 days of employment	
* If you are absent from work on the day your coverage would otherwise begin, coverage will start the day after you return to Montefiore, perform the usual duties of your job and work your regularly scheduled hours.		

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

If a family member (other than a newborn child) is hospitalized on the date coverage would otherwise begin, coverage will be delayed until the confinement ends.

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

Changing Your Enrollment Decisions During the Year

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

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

Qualified status changes include:

- Your marriage, divorce, legal separation or annulment
- Establishment or termination of a qualified domestic partnership
- Birth, adoption or legal guardianship of a dependent child
- Death of a family member
- Failure of a child to qualify as a dependent (i.e., he or she reaches the maximum age for coverage or is no longer handicapped)
- Change in your spouse's or qualified domestic partner's employment (either starts a new job or terminates employment) or involuntary loss of insurance coverage under another group plan
- Change in your, your spouse's, qualified domestic partner's or dependents' position or schedule that makes you or them ineligible for coverage
- Change in your unmarried, under age 25 child's status to dependent full-time student
- Change from a non-participating part-time to a full-time Montefiore RN
- Change from a full-time to an eligible part-time Montefiore RN
- Geographic relocation that changes your DMO membership options
- Strike or lockout involving you, your spouse, qualified domestic partner, or dependent
or
- Commencement or return from an unpaid leave of absence by you, your spouse, qualified domestic partner, or dependent.

If you experience a qualified change in status, and IRS change restrictions apply, you can modify your coverage provided:

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

Any change in coverage will generally take effect on the date of the status change. However, changes in your Life Insurance coverage which require approval by the insurance company will not become effective until you receive written notification from the insurance company that your application has been approved. Payroll adjustments will be reflected in the first paycheck you receive after Montefiore's HR-Benefits Office has been notified that the new coverage is effective.

If Your Pay Is Stopped or Reduced

If your pay is reduced for any reason, your contributions (if any) will continue as long as you remain eligible and your salary is sufficient to cover any required contributions. If your salary is not sufficient, you must make arrangements to prepay these premiums.

For example, your pay may be reduced if:

- You exhaust your paid time off benefits
- You switch from a full-time to a part-time schedule
- or*
- You are an eligible part-time RN whose schedule is reduced.

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

Coverage During Approved Leaves of Absence

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

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

- Continue healthcare coverage for yourself and any enrolled dependents and pay the required contributions
- or*
- Suspend coverage during your leave. (If you suspend coverage, you and your dependents will be covered on the day you return to work. Evidence of insurability will not be required.)

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

- You fail to pay the required contribution within 30 days of its due date
- or*
- The date you notify Montefiore that you will not return to work from your leave. (In this case, you will be required to reimburse the Registered Nurses Health Benefits Plan for the health insurance premiums paid during your leave unless your termination of employment is for reasons beyond your control.)

Military Leave – Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you can elect to continue healthcare coverage for the first six-months of a military leave, provided you continue to make any required contributions. If you remain absent from work for more than six-months, you can elect COBRA continuation coverage. Coverage for your family members remains in effect for six-months after which they can elect COBRA continuation coverage.

Personal Medical Leave – If you become disabled and are unable to work, healthcare coverage for you and your family members continues for six months, provided you continue to make any required contributions. After six months, coverage for your family members stops, unless they elect COBRA continuation coverage. Your healthcare coverage continues during the period you apply for Long Term Disability and Social Security disability benefits. Your coverage stops when your LTD and Social Security benefits are either approved or denied, but will not continue for longer than 24 months from the date you first became disabled. After your healthcare coverage stops, you can elect COBRA continuation coverage.

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

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

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

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

Paying for Coverage during a Leave

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

- Pre-pay the entire amount before your leave begins on a before-tax basis
- Have the contributions deducted on a before-tax basis from any supplementary sick pay
- or
- Make contributions on a monthly basis using after-tax dollars during your unpaid leave.

Healthcare

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

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Montefiore Medical Center Medical Benefits for Registered Nurses

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

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

Your Medical coverage provides benefits only for covered services and supplies that are medically necessary for the treatment of a covered illness or injury. **Only those services and supplies specifically listed as covered in this SPD are eligible for reimbursement through your medical benefits.**

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Glossary of Key Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Empire Behavioral Health Network (for Registered Nurses Health Plan participants) – A network of providers who specialize in mental health, alcoholism and substance abuse counseling and treatment.

Empire BlueCross BlueShield (Empire) – The Claims Administrator for the Registered Nurses Health Plan and Registered Nurses Dental Benefits. Empire is not the Claims Administrator for prescription drug benefits, Flexible Spending Accounts or Life Insurance.

Empire BlueCross BlueShield Indemnity Network – A national network of dentists, hospitals, laboratories and ancillary healthcare providers who have agreed to charge negotiated rates for their services, which are typically lower than they would otherwise charge. For more information or if you would like to find a network provider you can contact Empire at **866.236.6748** or online at www.empireblue.com/montefiore.

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

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

Express Scripts – The Claims Administrator for prescription drug benefits.

Formulary – A formulary is a list of medications approved by the U.S. Food and Drug Administration (FDA), including both brand name and generic drugs. Express Scripts – in conjunction with physicians and pharmacists – compiles the formulary list and evaluates the safety, effectiveness and affordability of the medications. They also update the list as the FDA approves new drugs.

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

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

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

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

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

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

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

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

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

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

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

Montefiore Medical Center Health Benefits Plan for Registered Nurses – Also referred to as the Registered Nurses Health Plan.

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.

Morbid Obesity – A condition in which:

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

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

Ophthalmologist – A physician who specializes in eye care.

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

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

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

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

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

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

Separate Admission – Two or more hospital admissions for:

- Unrelated causes
- or*
- The same or related condition separated by:
 - One day return to active work for you, your spouse or qualified domestic partner
 - Separated by at least 30 days for non-working family members.

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

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

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

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

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

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

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

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

Registered Nurses Health Plan

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

RN Plan Montefiore Provider Network

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

➤ **Physicians and Therapists:**

- A Montefiore Medical Group Primary Care Physician (PCP) at a Medical Group facility
- A salaried Montefiore specialist at a Montefiore facility. (This Network does not include voluntary Montefiore Primary Care Physicians or voluntary Montefiore specialists.)

➤ **Hospitals and Other Facilities** – Including Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital, Montefiore Ambulatory Surgical Facilities, Montefiore Imaging Center, Montefiore Department of Radiology, Advanced Endoscopy Center and NY GI Center

➤ **Laboratories** – Quest Laboratories, LabCorp, Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital laboratories.

Check the Empire Website – [www.empireblue.com/montefiore/MMG Directory](http://www.empireblue.com/montefiore/MMG_Directory) – for a list of network providers.

Preferred Provider Network

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

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

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

Provider Network Summary

Healthcare Providers	RN Plan Montefiore Provider Network	Preferred Provider Network
Physicians and Therapists	<ul style="list-style-type: none">▪ A Montefiore Medical PCP at a Medical Group facility▪ A salaried Montefiore specialist at a Montefiore facility.	Empire Indemnity Network
Hospitals and Other Facilities, Skilled Nursing Facility, Hospice	Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital, Montefiore Ambulatory Surgical Facilities, Montefiore Imaging Center, Montefiore Department of Radiology, Advanced Endoscopy Center and NY GI Center	Empire Indemnity Network
Laboratories	Quest Laboratories, LabCorp, Moses, Weiler, Wakefield, Westchester Square, The Children's Hospital at Montefiore, Montefiore New Rochelle Hospital, Montefiore Mt. Vernon Hospital laboratories	Any hospital laboratory participating in the Empire Indemnity Network

The Deductible

The *deductible* is the dollar amount that you must pay *before* the Registered Nurses Health Plan starts paying for certain expenses. The deductible is \$50 and applies to each individual once each calendar year. The covered expenses of all family members may be used to help meet the family maximum.

The following features help limit the deductibles you and your family members must pay:

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

Annual Out-Of-Pocket Maximum

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

Out-of-pocket Maximum (including Deductible + Copayments + Coinsurance)	Individual	Family
	\$5,600	\$11,200

Once the annual out-of-pocket maximum is reached, the Registered Nurses Health Plan pays 100% of all remaining eligible covered expenses for that individual (or family) for the rest of that calendar year.

Covered Expenses

In-hospital Care

The Registered Nurses Health Plan pays 100% – with no deductible – for semi-private hospital room and board and medical supplies for up to 365 days. If only private rooms are available, the RN Health Plan covers those charges up to the prevailing semi-private room rate in the area in which treatment is received.

Inpatient expenses include:

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

Coverage is also provided for:

- Cosmetic Surgery – if needed to repair damage caused by an accident or a birth defect
- Dental work or surgery if your physician certifies that hospitalization is necessary to safeguard your life
- Maternity care – a minimum of 48 hours following vaginal delivery; 96 hours following delivery by cesarean section; earlier release possible after consultation between the attending physician and the mother
- Organ and tissue transplants – if the covered person is the recipient (benefits for the donor will also be covered if that person is not covered by any other group health insurance plan)
- Prosthetics and orthotics – when billed with another covered service such as minor/ambulatory surgery, cataract surgery or breast reconstructive mandates
- Treatment in a hospital emergency room or similar facility for a bona fide medical emergency
- Well baby nursery and physicians' charges during the initial confinement while the mother is confined in the same hospital – for up to the number of days medically necessary and appropriate for the type of delivery (well baby nursery care will not be paid for any additional days the mother remains hospitalized due to an illness, injury or complications following delivery).

Inpatient Psychiatric Care/Substance Abuse

The RN Health Plan provides benefits for inpatient psychiatric care and substance abuse – in either a general hospital or special treatment facility (psychiatric hospital).

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

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

Registered Nurses Health Plan Benefit Summary

Here is a brief overview of the RN Health Plan.

	Registered Nurses Health Plan Your Cost If You Use: ¹		
	RN Montefiore Provider Network	Empire Indemnity Network	Out-of-network
Inpatient Medical/Surgical Services Hospital Inpatient Services and Ancillaries – semi-private room and board for up to 365 days <ul style="list-style-type: none"> ▪ Accidental Injury ▪ General Illness ▪ Inpatient Surgery ▪ Maternity ▪ Medical Rehabilitation ▪ Medical Supplies ▪ Mental Healthcare ▪ Organ Transplant ▪ Prosthetics and Orthotics ▪ Substance Abuse ▪ Well/Sick Newborn Care 	\$0	\$0	\$0
Emergency Room Care <ul style="list-style-type: none"> ▪ Bona Fide Emergency ▪ Other than a Bona Fide Emergency ▪ Urgent Care Facility 	\$0 \$0 \$0	\$0 \$0 20% ¹ coinsurance after deductible	\$0 \$0
Home Healthcare – up to a maximum of 100 visits each calendar year. Each visit by a member of a home healthcare team counts as one home healthcare visit. Up to four hours of home health aide services count as one home healthcare visit. Home healthcare benefits are limited to 12 hours of care a day. Covered services must be provided by a certified home health agency and include: <ul style="list-style-type: none"> ▪ 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. 	\$0	\$0	\$0
Hospice – for the medical care and treatment of a terminally ill patient for up to 210 days – provided the care is not primarily custodial.	\$0	\$0	\$0

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

² Reasonable and Customary charges are based on 330% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%.

Inpatient Medical/Surgical Services	Registered Nurses Health Plan Your Cost If You Use: ¹		
	RN Montefiore Provider Network	Empire Indemnity Network	Out-of-network
Skilled Nursing Facility – within 14 days after a hospital stay	\$0	\$0	\$0
Acupuncture – for the treatment of nausea and vomiting related to chemotherapy and pregnancy, osteoarthritis of the knee, post-operative dental pain, and post-operative nausea and vomiting in adults – limited to 12 treatments in a 12 month period	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Advanced Reproductive Technologies – up to a maximum lifetime benefit of \$5,000; for treatment (hospital, surgical, medical and prescription drugs) related to infertility including: <ul style="list-style-type: none"> ▪ artificial insemination ▪ in-vitro fertilization /ZIFT/GIFT/ICSI 	\$0	\$0 up to \$2,000, 20% ¹ coinsurance after deductible thereafter	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Allergy Care – Office Visits, Testing, Treatment	\$0	20% ¹ coinsurance	20% ² coinsurance
Ambulance Service – in a medical emergency to the nearest medical facility equipped to treat that condition or if medically necessary	20% coinsurance	20% ¹ coinsurance	20% coinsurance
Ambulatory Surgical Facility	\$0	\$0	\$0
Anesthesia Services – if performed by a licensed anesthesiologist in connection with a surgical procedure	\$0	\$0	\$0
Assistant Surgeons' Fees	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Birth Control – IUDs, diaphragm fittings, Norplant	\$0	\$0	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Birthing Center	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Blood, Blood Plasma or Blood Derivatives	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Cardiac Rehabilitation	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Chemotherapy –non-cancer and cancer	\$0	20% ¹ coinsurance	20% ² coinsurance
Chiropractic Services (limited to \$1,000 in a calendar year)	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance
Consultations	\$0	20% ¹ coinsurance	20% ² coinsurance
Dental Services <ul style="list-style-type: none"> ▪ extractions of impacted wisdom teeth and other teeth impacted in bone which require oral surgery ▪ treatment of an injury to sound natural teeth within 12 months of the date of injury 	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Diagnostic X-rays – including MRI, MRA, PET, CAT scans, Nuclear Cardiology	\$0	20% ¹ coinsurance	20% ² coinsurance
Durable Medical Equipment – purchase and rentals	N/A	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible

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² Reasonable and Customary charges are based on 330% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%.

Inpatient Medical/Surgical Services	Registered Nurses Health Plan Your Cost If You Use: ¹		
	RN Montefiore Provider Network	Empire Indemnity Network	Out-of-network
Foot Care – routine care for up to 8 visits in a calendar year, including removal of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain	\$0	20% ¹ coinsurance	20% ² coinsurance
Genetic Testing (physician must certify that it is medically necessary)	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Hearing Care – exams, hearing aids (including repairs and batteries)	N/A	\$0	\$0
Hemodialysis	\$0	20% ¹ coinsurance	20% ² coinsurance
Immunizations – Hepatitis A, annual flu shot, tetanus, Pneumococcal	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Injections/Biologicals – including injections for Depo-Provera	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Laboratory Tests	\$0	20% ¹ coinsurance	20% ² coinsurance
Medical Supplies	\$0 when billed with other covered services i.e., chemotherapy, surgery	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Mental Healthcare – outpatient facility and professional services	\$0	20% ¹ coinsurance	20% ² coinsurance
Morbid Obesity – surgical treatment (limited to one procedure in a lifetime)	\$0	\$0 up to \$2,000, 20% ¹ coinsurance after deductible thereafter	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Nutritional Counseling – up to six sessions each calendar year, if referred by a physician. In-network providers are Registered Dietitians in the Empire BlueCard PPO Network, including Montefiore Registered Dietitians.	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Obstetrical (Maternity) Care – including: <ul style="list-style-type: none"> ■ termination of pregnancy ■ certified nurse-midwife 	\$0	\$0 up to \$2,000, 20% ¹ coinsurance after deductible thereafter	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Occupational, Respiratory and Speech Therapy	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Orthotics	N/A	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Physical Therapy	\$0	20% ¹ coinsurance	20% ² coinsurance
Physicians' Visits			
<ul style="list-style-type: none"> ■ In-hospital by your attending physician 	\$0	20% ¹ coinsurance	20% ² coinsurance
<ul style="list-style-type: none"> ■ Office visits including emergency care/first aid and medical evaluations 	\$0	20% ¹ coinsurance	20% ² coinsurance
Polysomnograms – for the treatment of sleep apnea, narcolepsy, insomnia, sleep walking, night terrors and bed wetting	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible

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

² Reasonable and Customary charges are based on 330% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%.

Inpatient Medical/Surgical Services	Registered Nurses Health Plan Your Cost If You Use: ¹		
	RN Montefiore Provider Network	Empire Indemnity Network	Out-of-network
Pre-surgical/Pre-admission Tests – if performed within 14 days of a scheduled hospital admission	\$0	\$0	\$0
Preventive Care <ul style="list-style-type: none"> ▪ Routine Physical Exam with PCP including OB/GYN ▪ Routine Child Exam/Immunizations ▪ Routine Mammography 	\$0	\$0	You may be balance billed for amounts in excess of in-network reimbursement
Prosthetics – including lenses and/or glasses after cataract surgery, artificial limbs and eyes, wigs and toupees	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Radiation Therapy	\$0	20% ¹ coinsurance	20% ² coinsurance
Reconstructive Surgery Following a Mastectomy including: <ul style="list-style-type: none"> ▪ reconstruction of the breast on which the mastectomy was performed ▪ surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses ▪ treatment of physical complications at all stages of the mastectomy, including lymphedemas 	\$0	\$0 up to \$2,000, 20% ¹ coinsurance after deductible thereafter	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Second Surgical Opinions	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Shock Therapy	\$0	20% ¹ coinsurance	20% ² coinsurance
Sleep Disorders – treatment of sleep apnea and narcolepsy	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Sterilization (but not reversals)	\$0	\$0 up to \$2,000, 20% ¹ coinsurance after deductible thereafter	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Substance Abuse Treatment	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Surgeons' Fees	\$0	\$0 up to \$2,000, 20% ¹ coinsurance after deductible thereafter	\$0 up to \$2,000, 20% ² coinsurance after deductible thereafter
Vision Therapy (up to 30 visits each calendar year at MMC Clinic only)	\$0	20% ¹ coinsurance after deductible	20% ² coinsurance after deductible
Well Baby Care – limited to 11 visits up to age 2	\$0	\$0	20% ² coinsurance

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

² Reasonable and Customary charges are based on 330% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%.

Inpatient Medical/Surgical Services	Registered Nurses Health Plan Your Cost If You Use: ¹		
	RN Montefiore Provider Network	Empire Indemnity Network	Out-of-network
Well Woman Care <ul style="list-style-type: none"> Screening for gestational diabetes HPV testing Contraceptive methods and counseling Breast feeding support, supplies and counseling Counseling for sexually transmitted infections Counseling and screening for HIV Screening and counseling for interpersonal and domestic violence 	\$0	\$0	You may be balance billed for amounts in excess of in-network reimbursement

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

² Reasonable and Customary charges are based on 330% of Medicare's National Provider Rate. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%.

Vision

LASIK Surgery

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

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

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

If you want to learn how to use your Health Care FSA to help pay for the surgery, please contact HR Benefits at **914.378.6531** or through montebenefits@montefiore.org.

Maximum Benefits

The Registered Nurses Health Plan provides unlimited lifetime medical benefits for you and each covered family member. However, some covered services are subject to separate limits and/or annual maximum benefits. These limits and maximums apply to each covered individual and are:

- Acupuncture – limited to 12 treatments in a 12 month period
- Advanced reproductive technologies – up to a maximum lifetime benefit of \$5,000
- Chiropractic services – up to \$1,000 each calendar year
- Foot care – up to eight visits in a calendar year
- Home healthcare – up to 100 visits each calendar year
- Hospice care – up to 210 days
- Morbid obesity – limited to one surgical procedure in a lifetime
- Nutritional counseling – up to six counseling sessions in a calendar year
- Physical exams (routine) – once in a calendar year
- Vision therapy – up to 30 visits each calendar year only at MMC Clinic
- Well-baby care – limited to 11 visits up to age 2.

Exclusions

The Registered Nurses Health Plan does not pay for all medical services and supplies – even if recommended by a physician. Expenses **not** covered include:

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

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

- Services or supplies:
 - Covered under the mandatory portion of a no-fault automobile insurance policy, if no-fault benefits are recovered or recoverable
 - For medical procedures or treatments
 - Considered experimental, investigational or educational
 - Not medically necessary for treatment of your condition
 - Provided primarily for research
 - Not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury
 - For recreational therapy
 - For smoking cessation programs including transdermal patches or Nicorette gum
 - For which there is no legal obligation to pay or charges that would not have been made except for the availability of benefits from the Registered Nurses Health Plan
 - Not ordered by a physician
 - Provided by a Health Maintenance Organization (HMO)
 - Provided by the government, unless you are legally required to pay for the care you receive
 - **Which are not specifically listed as covered expenses in this Summary Plan Description**
 - Which result from illness or injuries caused by a third party unless a subrogation agreement has been executed by you and/or the appropriate family member
- Sex change surgery or any treatment of gender identity disorders
- Sleeping disorders – including bruxism (grinding of teeth), drug dependency, dream anxiety attacks, shift work or schedule disturbances, migraine headaches (except as specified under covered services)
- Sterilization – procedures to reverse voluntary sterilization
- Surrogate expenses
- Telephone calls or medical advice provided by telecommunications
- TMJ – temporomandibular joint dysfunction – surgical and non-surgical treatment
- Travel or lodging expenses for a physician or a patient, except for emergency ambulance service
- Vaccinations, inoculations or immunizations, except as specified under covered services
- Vision benefits
- Vision perception training
- Vitamins, minerals and food supplements
- Weight reduction – treatment, instructions, activities or drugs for weight reduction or control, except as diagnosed condition of morbid obesity.

Coordination of Benefits (COB)

The Montefiore Medical Center Health Plan for Registered Nurses contains a coordination of benefits (COB) feature. This feature applies when you or a family member is covered by more than one group medical plan. It limits payments from all sources combined to 100% of covered expenses subject to Plan maximums. Coordination of benefits also applies to Medicare, Champus/Tricare and any other government programs with which the Registered Nurses Health Plan is allowed to coordinate by law. The coordination of benefits provision does not apply to any personal policy, except no-fault automobile insurance. This provision does not apply to Medicaid or any other government programs with which the Registered Nurses Health Plan is not allowed to coordinate by law. Medicare follows different rules than those explained below – see [“Coordination with Medicare”](#).

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

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

Claims should always be submitted to the primary plan first.

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

Coordination with an HMO

The Montefiore Medical Center Health Plan for Registered Nurses also coordinates benefits with an HMO if:

- You are covered as a dependent under your spouse's (or qualified domestic partner's) HMO and are also enrolled in Montefiore's Registered Nurses Health Plan

or

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

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

Coordination with Medicare

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

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

If you are actively employed, age 65 or over and eligible for Medicare, you can elect primary coverage under Medicare. However, if you do, no benefits will be payable under Montefiore's program. If you do not elect Medicare, you will continue to be covered under the Registered Nurses Health Plan.

If You Continue to Work After Age 65

At age 65, or earlier if disabled, you will become eligible for Medicare, a U.S. federal government health insurance program. You can enroll in Medicare whether you continue to work or not. But if you continue to work, you also remain eligible for the Registered Nurses Benefits Program.

If you continue to work, you or your spouse or qualified domestic partner age 65 or over have the option to continue to be covered by Montefiore Medical benefits. If you choose to be covered by Montefiore Medical benefits and have enrolled in Medicare, Montefiore's coverage will be primary to Medicare. Medicare will become your secondary plan and provide coverage for eligible expenses that your Health Plan does not cover. If you are working for Montefiore when your spouse or qualified domestic partner becomes Medicare eligible, he or she will have the same coverage as you have elected for yourself, if you elect family coverage.

If you make no election with respect to Medicare, you will continue to be covered by the Montefiore Medical Center Health Plan for Registered Nurses until the date that you are no longer eligible for coverage, whichever is earlier.

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

Before you reach age 65, you should contact your local Social Security office to notify them that you will remain actively employed and have elected to continue coverage under your employer's Medical Plan. Otherwise, you will be charged a higher premium for Medicare Part B when these benefits begin.

If you are age 65 and eligible for Medicare because of a disability, the Montefiore Medical Center Health Plan for Registered Nurses will be the primary payer if you are entitled to Medicare Part A and are covered as a result of your or a family member's current employment status. However, if you are disabled as a result of End Stage Renal Disease ("ESRD") your coverage under the Montefiore Medical benefits will only be primary for a 30-month period beginning with either: (1) the first of the month in which you become entitled to Medicare Part A on the basis of ESRD or (2) the first of the month you would have been entitled had you applied, whichever occurs first.

Since Medicare rules are complicated, you are encouraged to contact Montefiore's HR-Benefits Office in the event of a disability.

Prescription Drug Benefits

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

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

If you purchase a prescription drug from a non-participating pharmacy, you will be required to pay for the prescription and submit a Prescription Drug Claim Form to be reimbursed. If you use a non-participating pharmacy in an area where there is a participating pharmacy available, your reimbursement will be 75% of the R&C cost of the prescription.

- Up to a 90-day supply of each prescription drug through the Home Delivery Pharmacy Service – subject to copayments. Remember that it takes approximately 14 days to receive your prescription – so make sure you keep an adequate supply of your medications on hand.

Prescription Drug Out-of-pocket Maximum

Your share of expenses for prescriptions obtained from Express Scripts participating retail pharmacies, home delivery pharmacy service or out-of-network pharmacies is limited to \$1,000 for any one covered person (\$2,000 for a family) in a calendar year. Once that maximum is reached, the Plan pays 100% of any remaining prescription drug expenses for that individual for the rest of the calendar year.

If you purchase a brand name medication (preferred and non-preferred) when a generic equivalent is available, you are responsible for the retail or mail order generic copayment plus the difference in cost between the generic and the brand name medication. The difference in cost between generic and the brand name medications is not included in the out-of-pocket maximum and is not eligible for 100% reimbursement after the out-of-pocket maximum has been met.

Benefit Summary

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

If I Use	Your Cost If You Use:		
	Generic	Preferred Brand Name	Non-preferred Brand Name
Montefiore Outpatient Pharmacies – Montefiore Pharmacy Formulary Drugs (up to a 90-day supply of each prescription)	\$0	\$0	\$0
Express Scripts			
▪ Participating Retail Pharmacy ² (up to a 30-day supply of each prescription)	\$7 copay	\$10 copay	\$20 copay
▪ Home Delivery Pharmacy Service (up to a 90-day supply of each prescription)	\$7 copay	\$10 copay	\$20 copay
¹ If you use a non-participating pharmacy in an area where there is a participating pharmacy available, your reimbursement will be 75% of the R&C cost of the prescription.			

Utilization Management Features

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

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

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

- **Preferred Drug Step Therapy (PDST)** – This feature requires you to try a generic alternative or preferred brand name medication before a higher cost non-preferred brand name drug is used. Generic alternatives are generic drugs that are approved by the FDA for the same or similar use i.e., where they are clinically interchangeable. Generic alternatives are not the same as generic equivalents, which have the same active ingredients and treat the same conditions. 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.) This feature generally applies to the following drug categories: Angiotensin II Receptor Blockers (ARBs), Atypical antipsychotics (Abilify, Saphris, Invega), Anti-Depressants, Celebrex, CNS Stimulants & Amphetamines, Dermatologicals, Gastrointestinal, Intranasal Steroids, Migraine Medications, Osteoporosis, Pain Management (Fentora, Onsolis, Abstral), Rheumatoid Arthritis, Synagis, Pulmonary Arterial Hypertension, Rebetal, Cobegus and Sleep Medications. Express Scripts will notify you if you are currently taking non-preferred drugs that have lower cost alternatives available.
- **Drug Specific Prior Authorization** – ensures that drugs are being used for their intended purpose. If you are taking any of the following classifications of drugs, Express Scripts will review your prescriptions and contact your doctor to determine if your prescription qualifies for drug coverage based on nationally accepted clinical guidelines and standards: Anabolic Steroids, Anti Narcoleptic Agents, Cosmetics, Dermatological Agents, Erythroid Stimulants, Human Growth Hormone, Immunomodulatory Agents, Interferons, Misc. Hormones-Acthar H.P. Gel (Specialty), Multiple Sclerosis Therapy, Myeloid Stimulants, Select Androgens, Specialty and Weight Loss Agents. If you are taking drugs that require prior authorization, Express Scripts will notify you and provide you with instructions for beginning a coverage review.

Quantity/Dose Limitations

Prescriptions for generic and brand name medications will only be filled in quantities and doses that are consistent with manufacturer and FDA clinical guidelines. If your doctor prescribes a drug in a quantity/dose that exceeds these guidelines your prescription will be filled according to the guidelines. If you are currently taking a drug in a quantity that is affected by these guidelines you will be pre-notified by Express Scripts – at which point you or your physician can initiate a coverage review process in order for greater quantities to be filled.

▪ Anticonvulsant (Lyrica)	▪ Migraine medications (Amerge, Axert, Frova, Imitrex, Maxalt, Migranal NS, Relpax, Zomig)
▪ Anti-emetics	▪ Nausea medications (Anzemet, Emend, Kytril, Zofran)
▪ Anti Narcoleptic Agents – Provigil, Nuvigil	▪ Osteoporosis (Bisphosphonates, Actonel, Boniva, Fosamax)
▪ Diabetes (Byetta)	▪ Pain Management (Lidoderm)
▪ Erectile dysfunction therapy (Caverject, Cialis, Edex, Levitra, MUSE, Viagra)	▪ Pain Management – Narcotic Analgesics (Actiq, Fentora)
▪ Hypnotic agents (Ambien, Ambien CR, Lunesta, Rozerem, Sonata)	▪ Psoriasis Therapy (Amevive, Raptive, Enbrel – Specialty).
▪ Hepatitis C (Incivek, Victrelis)	▪ Xifaxan
▪ Lovaza	

Medicare Part D Notice

Important Notice from Montefiore Medical Center about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Montefiore 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:

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Montefiore coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Montefiore 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 October to join.

For More Information about this Notice or Montefiore Prescription Drug Coverage

Call Montefiore's HR-Benefits Office at **914.378.6531**.

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

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" Handbook. You'll get a copy of the Handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	1/1/2015
Name of Entity/Sender:	Montefiore Medical Center
Contact – Position/Office:	HR-Benefits Office
Address:	111 East 210 th Street Bronx, NY 10467-2490
Phone Number:	914.378.6531

Montefiore Medical Center Dental Benefits for Registered Nurses

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

What the Dental Section Includes

- Glossary of Key Terms 47
- An Overview of Your Dental Options..... 49
- Treatment Using Preferred Providers..... 50
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- Pre-Treatment Review (Registered Nurses Dental Benefits)..... 57
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- Coordination of Benefits 60
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Glossary of Key Terms

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

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

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

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

Deductible – The dollar amounts that you must pay each year for certain covered services before Registered Nurses Dental Benefits and the DMO (out-of-network in New York and Connecticut) start paying part of the costs.

Dental Maintenance Organization (DMO) – The DMO is a group of healthcare professionals and facilities that provide dental care. The DMO covers a wide range of dental services and typically requires a copayment for office visits and certain other services.

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

Doctor (or physician) – An individual holding a degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), Doctor of Podiatric Medicine (DPM) or Doctor of Chiropractic (DC), 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 BlueCross BlueShield (Empire) – The Claims Administrator for the Registered Nurses Health Plan and Registered Nurses Dental Benefits. Empire is not the Claims Administrator for prescription drug benefits, Flexible Spending Accounts, HMOs or Life Insurance.

Empire Dental Prime and Complete Member Services Network (for Registered Nurses Dental Benefits participants) – A national network of dental providers (including the Montefiore Medical Center Department of Dentistry) who have agreed to charge negotiated rates for their services, which are typically lower than they would otherwise charge. For more information or if you would like to find a network provider you can contact Empire at **866.236.6748** or online at www.empireblue.com/montefiore.

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

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. 80% or 50%) to this amount; you are responsible for paying the balance of the bill to the provider.

The Reasonable and Customary payment schedule does not apply to services provided by the Empire Dental Premium Care PPO Network including the Montefiore Medical Center Department of Dentistry.

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

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

An Overview of Your Dental Options

As an eligible registered nurse, you can choose Montefiore's Dental Benefits for Registered Nurses, the Dental Maintenance Organization (DMO) or you can elect no coverage.

The DMO

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

- Your out-of-pocket dental expenses are typically lower than under Registered Nurses Dental Benefits
 - You make copayments only for specified covered services
 - You have no deductibles to pay
 - There are virtually no claim forms to fill out
- and*
- You don't have to wait to be reimbursed (subject to certain limitations and exclusions).

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

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

You and your covered family members can choose the same network primary care dentist or you can select a different dentist for each. The DMO network is nationwide, so even students away from home at school can choose their own network primary care dentist. You can change your network primary care dentist once a month. If you call by the 15th of the month, the change will be effective the first of the following month. All you do is call **1-800-THE-DMO1**.

If you use out-of-network dentists (or see a network specialist without the required referral from your primary care dentist) while enrolled in the DMO, benefits are determined based on your state of residence. Any out-of-network benefits that may be payable are based on a schedule, and generally subject to a \$100 individual annual deductible.

Treatment Using Preferred Providers

Montefiore's Registered Nurses Dental Benefits provide access to the Empire Dental Prime and Complete Member Services Network including the Montefiore Medical Center Department of Dentistry. Plan participants can receive treatment from dentists who have agreed to provide services at a discount. Just like the Empire Network for health benefits, the discount applies to the cost of covered services provided. It does not affect the cost-sharing percentages established by the Plan. You are not required to use these providers, but you may save money if you do. Check the Empire Website (www.empireblue.com/montefiore/Find A Dentist) for a list of participating dentists.

The Deductible

The deductible is the dollar amount that you must pay before the Registered Nurses Dental Benefits and the DMO (out-of-network in New York and Connecticut) start paying benefits for certain expenses. The deductible applies to each covered individual once each calendar year.

The DMO deductible is \$100. Under the DMO, out-of-network preventive, basic and major services (not orthodontic care) are subject to the deductible.

The Registered Nurses Dental Benefits deductible is \$25. Amounts you pay toward preventive, basic, major and orthodontic services count toward satisfying the deductible.

Covered Expenses

Both options provide benefits for the covered services shown in the following table. ***Only expenses specifically listed in this SPD are covered; all other expenses are excluded.***

	DMO – Your Cost If You Use: ³		
Dental Services and Supplies	In-network	Maximum Out-of-network Benefit	RN Dental Benefits ² Your Cost If You Use: ³
PREVENTIVE AND DIAGNOSTIC SERVICES			
Office Visits and Exams			
▪ Office visit for oral examination	\$0	\$12	20% coinsurance after the \$25 annual deductible (once every 6 months)
	(limited to 4 visits a year)		
▪ Emergency palliative treatment	\$0	\$12	20% coinsurance after the \$25 annual deductible
▪ Prophylaxis (cleaning)	\$0	\$26 – Adult \$14 – Child	20% coinsurance after the \$25 annual deductible (once every 6 months)
	(limited to 2 treatments a year)		
▪ Oral hygiene instruction	\$0	\$12	Not covered
▪ Pulp vitality test	\$0	\$8	20% coinsurance after the \$25 annual deductible
▪ Diagnostic casts	\$0	\$20	20% coinsurance after the \$25 annual deductible
▪ Topical application of fluoride (1 treatment a year)	\$0	\$16	20% coinsurance after the \$25 annual deductible (for children under age 19)
	(for children under age 18)		
▪ Sealants, per tooth	\$0	\$10	20% coinsurance after the \$25 annual deductible (limited to 1 application in a 36-month period on molars for children under age 14)
	(limited to 1 application every 3 years on permanent molars only)		
X-rays and Pathology			
▪ Bitewing X-rays (2 sets/year)	\$0	\$8	20% coinsurance after the \$25 annual deductible Full Mouth series and Panoramic film – 1 set every 3 years
▪ Entire series, including bitewings, or panoramic film (1 set/3 years)	\$0	\$14	
▪ Vertical bitewing X-rays (1 set/3 years)	\$0	\$12	
▪ Periapical X-rays	\$0	\$6	
▪ Intra-oral, occlusal view, maxillary, or mandibular	\$0	\$8	
▪ Extra-oral upper or lower jaw	\$0	\$12	
▪ Biopsy and histopathologic examination of oral tissue	\$0	\$27	

¹ Out-of-network benefits are only available to DMO participants who live in New York or Connecticut. If you live in New Jersey no out-of-network benefits will be paid except in an emergency. Out-of-network covered services, except orthodontic care, are subject to a \$100 individual annual deductible.

² 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. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%; when you pay 50%; the plan pays 50%.

Dental Services and Supplies	DMO – Your Cost If You Use: ³		RN Dental Benefits ² Your Cost If You Use: ³
	In-network	Maximum Out-of-network Benefit	
BASIC SERVICES			
Endodontics			
▪ Pulp capping	\$0	\$3	20% coinsurance after the \$25 annual deductible
▪ Pulpotomy	\$0	\$27	
▪ Surgical exposure for rubber dam isolation	\$0	\$26	
▪ Root canal therapy, including necessary X-rays			
– anterior	\$0	\$80	
– bicuspid	\$0	\$96	
▪ Apexification/recalcification	\$0	\$32 per visit	
▪ Apicoectomy (per tooth) – first root	\$0	\$60	
▪ Apicoectomy (per tooth) – each additional root	\$0	\$40	
▪ Retrograde filling	\$0	\$14	
▪ Root amputation	\$0	\$27	
▪ Hemisection	\$0	\$27	
▪ Molar root canal therapy, including necessary X-rays	20% coinsurance	\$120 (if complex)	
Restorations and Repairs			
▪ Amalgam restoration (silver fillings)			20% coinsurance after the \$25 annual deductible
– 1 surface	\$0	\$12	
– 2 surfaces	\$0	\$16	
– 3 or more surfaces	\$0	\$24	
▪ Resin restorations (other than for molars)			
– 1 surface	\$0	\$12	
– 2 surfaces	\$0	\$16	
– 3 or more surfaces or incisal angle	\$0	\$26	
▪ Retention pins	\$0	\$14	
▪ Sedative fillings	\$0	\$12	
▪ Stainless steel crowns	\$0	\$26	
▪ Prefabricated resin crowns (excluding temporary crowns)	\$0	\$60	
▪ Recementing inlays, crowns, bridges, space maintainers	\$0	\$16	
▪ Tissue conditioning for dentures	\$0	\$26	

¹ Out-of-network benefits are only available to DMO participants who live in New York or Connecticut. If you live in New Jersey no out-of-network benefits will be paid except in an emergency. Out-of-network covered services, except orthodontic care, are subject to a \$100 individual annual deductible.

² 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. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%; when you pay 50%; the plan pays 50%.

Dental Services and Supplies	DMO – Your Cost If You Use: ³		RN Dental Benefits ² Your Cost If You Use: ³
	In-network	Maximum Out-of-network Benefit	
BASIC SERVICES			
Periodontics			
▪ Emergency treatment (abscess, acute periodontitis, etc.)	\$0	\$26	20% coinsurance after the \$25 annual deductible
▪ Subgingival curettage (limited to 4 separate quadrants, every year)	\$0	\$40	
▪ Scaling and root planning (limited to 4 separate quadrants, every year)	\$0	\$40	
▪ Periodontal maintenance procedures following surgical therapy (limited to 2 a year)	\$0	\$40	
▪ Gingivectomy or gingivoplasty – per quadrant	\$0	\$40	
▪ Gingivectomy or gingivoplasty – per tooth	\$0	\$20	
▪ Gingival flap procedure – per quadrant	\$0	\$60	
▪ Free soft tissue graft	\$0	\$60	
▪ Osseous surgery (including flap entry and close), per quadrant	20% coinsurance	\$80	
▪ Occlusal adjustment (other than with an appliance or by restoration)	\$0	\$20 limited) \$40 (entire mouth)	Not Covered
Oral Surgery (includes local anesthetics and routine post-operative care)			
▪ Extractions, uncomplicated	\$0	\$27	20% coinsurance after the \$25 annual deductible (except for impacted wisdom teeth or other teeth impacted in the bone, which are covered under Medical benefits)
▪ Surgical removal of erupted tooth	\$0	\$32	
▪ Surgical removal of impacted tooth	\$0	\$40	
▪ Excision of hyperplastic tissue	\$0	\$32	
▪ Excision of pericoronal gingiva	\$0	\$40	
▪ Incision and drainage of abscess	\$0	\$20	
▪ Crown exposure to aid eruption	\$0	\$26	
▪ Removal of foreign body from soft tissue	\$0	\$20	
▪ Suture of soft tissue injury	\$0	\$20	
▪ Removal of residual root	\$0	\$27	
▪ Removal of odontogenic cyst	\$0	\$40	
▪ Closure of oral fistula	\$0	\$48	
▪ Removal of foreign body from bone	\$0	\$20	
▪ Sequestrectomy	\$0	\$20	

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Dental Services and Supplies	DMO – Your Cost If You Use: ³		RN Dental Benefits ² Your Cost If You Use: ³
	In-network	Maximum Out-of-network Benefit	
BASIC SERVICES			
Oral Surgery (includes local anesthetics and routine post-operative care)			
▪ Frenectomy	\$0	\$40	20% coinsurance after the \$25 annual deductible (except for impacted wisdom teeth or other teeth impacted in the bone, which are covered under Medical benefits)
▪ Transplantation of tooth or tooth bud	\$0	\$48	
▪ Alveoplasty in conjunction with extractions – per quadrant	\$0	\$27	
▪ Alveoplasty not in conjunction with extractions – per quadrant	\$0	\$40	
▪ Removal of exostosis	\$0	\$60	
▪ Sialolithotomy; removal of salivary calculus	\$0	\$36	
▪ Closure of salivary fistula	\$0	\$36	
▪ Surgical removal of impacted teeth			Not Covered (covered under Medical benefits)
– Partial bony	20% coinsurance	\$53	
– Completely bony	20% coinsurance	\$60	
– Completely bony with unusual surgical implications	20% coinsurance	\$64	
Sedation/Anesthesia – Intravenous sedation and general anesthesia	20% coinsurance	\$120 (per 15 minute segment)	20% coinsurance after the \$25 annual deductible
MAJOR SERVICES			
Prosthodontics			
▪ Inlays			50% coinsurance after the \$25 annual deductible
– 1 surface	20% coinsurance	\$60	
– 2 or more surfaces	20% coinsurance	\$80	
▪ Onlays			
– 2 surfaces	20% coinsurance	\$80	
– 3 or more surfaces	20% coinsurance	\$80	
▪ Post and core	20% coinsurance	\$27	Repair/replacement of crowns and pontics payable 5 years after initial placement
▪ Crowns (including build-ups when necessary)	20% coinsurance	\$120	
▪ Pontics	20% coinsurance	\$20	

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² 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. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%; when you pay 50%; the plan pays 50%.

Dental Services and Supplies	DMO – Your Cost If You Use: ³		RN Dental Benefits ² Your Cost If You Use: ³
	In-network	Maximum Out-of-network Benefit	
MAJOR SERVICES			
Prosthodontics			50% coinsurance after the \$25 annual deductible
<ul style="list-style-type: none"> ▪ Dentures and partials (includes relining, rebasing and adjustments within 6 months after installation) 			<ul style="list-style-type: none"> ▪ only one relining or rebasing is covered in any 36 consecutive month period
— Complete (upper or lower)	20% coinsurance	\$120	<ul style="list-style-type: none"> ▪ initial installation of dentures for the loss or extraction of natural teeth while you or a family member is covered by Dental benefits; if dentures are for teeth lost or extracted before your Dental coverage begins, Dental benefits will pay 50% of the benefit otherwise payable until the individual has been covered by the program for 24 months
— Partial	20% coinsurance	\$120	
— Interim partial denture (stayplates); anterior only	20% coinsurance	\$40	
— Crown and bridge repairs	20% coinsurance	\$27	
— Adding teeth to an existing denture	20% coinsurance	\$40	
— Full and partial denture repairs	20% coinsurance	\$27	
— Relining/rebasing dentures (includes adjustments within six months after installation)	20% coinsurance	\$40	<ul style="list-style-type: none"> ▪ initial installation of fixed bridgework to replace teeth extracted while you are a member of Dental benefits; 12-month minimum membership in Dental benefits is required
— Stress breakers (per unit)	20% coinsurance	\$40	Not covered
▪ Occlusal guard (for bruxism only)	20% coinsurance	\$40	Not covered

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² 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. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%; when you pay 50%; the plan pays 50%.

Dental Services and Supplies	DMO – Your Cost If You Use: ³		RN Dental Benefits ² Your Cost If You Use: ³
	In-network	Maximum Out-of-network Benefit	
MAJOR SERVICES			
<ul style="list-style-type: none"> Replacement of, or addition or modification to existing dentures, crowns, casts or processed restorations, removable bridges or fixed bridgework if: <ul style="list-style-type: none"> The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture was installed and for the DMO, the individual was a dental participant when the extraction occurred; for RN Dental Benefits, the person had been a participant for at least 24 months, or The existing appliance cannot be made serviceable and was installed at least five years before the replacement The existing denture is a temporary one to replace one or more natural teeth extracted while the individual was a Dental participant, cannot be made permanent and replacement by a permanent denture is required. The replacement must be made within 12 months after the temporary denture is installed. 	20% coinsurance	Not covered	50% coinsurance after the \$25 annual deductible
Space Maintainers (includes all adjustments within 6 months after installation)			
<ul style="list-style-type: none"> Fixed band type 	20% coinsurance	\$40	20% coinsurance after the \$25 annual deductible
<ul style="list-style-type: none"> Removable acrylic with round wire clasp 	20% coinsurance	\$32	
<ul style="list-style-type: none"> Removable appliance to correct habits 	20% coinsurance	\$32	Not covered
<ul style="list-style-type: none"> Fixed or cemented appliance to correct habits 	20% coinsurance	\$40	Not covered
ORTHODONTIC SERVICES			
Orthodontics , including: <ul style="list-style-type: none"> Comprehensive orthodontic treatment Post treatment stabilization Interceptive orthodontic treatment Limited orthodontic treatment 	50% coinsurance	\$800 (individual lifetime maximum)	20% coinsurance after the \$25 annual deductible
Lifetime Orthodontic maximum	None	1 course of treatment	\$1,500
Annual maximum benefits for each covered person (Preventive and Diagnostic, Basic and Major Services combined)	None	None	\$1,300

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² 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. The Plan benefit is then determined by applying the cost-sharing percentage (70%/80%) to this amount; you are responsible for paying the balance of the bill to the provider.

³ Coinsurance – when you pay 20%, the plan pays 80%; when you pay 50%; the plan pays 50%.

Pre-treatment Review (Registered Nurses Dental Benefits)

Pre-treatment review lets you know in advance how much Registered Nurses Dental Benefits will reimburse you when extensive dental work is expected.

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

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

Alternate Treatment (DMO)

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

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

Out-of-Area Emergency Treatment (DMO)

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

Maximum Benefits

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

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

Exclusions

Your Dental options do *not* pay benefits for all dental services and supplies – even if recommended by a dentist. Expenses *not* covered include:

- Appliances to correct harmful habits, such as grinding of teeth, thumb sucking, etc., 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 or benefit request forms
 - For services performed after 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 charges
 - Incurred before you or one of your family members became a dental participant
 - Incurred outside the United States or its territories except in a medical emergency
 - To the extent they are reimbursable under another employer's plan or any other source of payment
- Extractions of impacted wisdom teeth and other teeth impacted in the bone (covered by RN Health Plan)
- 50% of the benefit otherwise payable for dentures or bridgework for teeth lost or extracted before your Dental coverage begins (full coverage is provided once the person has been a Dental participant for at least 24 months)
- Hospital charges
- Illness or injury – treatment of occupational illness or injury

- Installation of a crown, cast or processed restoration (for those enrolled in the DMO) unless:
- Treatment for decay or traumatic injury cannot be restored with a filling material, or
- The tooth is an abutment to a covered partial denture or fixed bridge
- Mailing or shipping expenses
- Myofunctional therapy
- 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
- Pontics, crowns, casts or processed restorations made with high noble metals (for those enrolled in the DMO)
- 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 this Dental coverage
 - Not necessary for the diagnosis, care or treatment of the condition involved – even if prescribed by a physician or dentist
 - Not ordered or performed by a physician, dentist or other licensed dental practitioner
 - Provided by a Health Maintenance Organization or Dental Maintenance Organization (if you are a participant in RN Dental Benefits)
 - 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
- Teeth implants and any related charges
- Treatment of any jaw joint disorder including temporomandibular joint dysfunction (TMJ)
- Veneers or facings on molar crowns and pontics.

Coordination of Benefits

Registered Nurses Dental Benefits contain a coordination of benefits (COB) feature. This feature applies when you or an eligible family member is covered by more than one group plan providing dental benefits. It limits combined benefits from all group dental plans to 100% of covered expenses subject to Plan maximums. Under the coordination of benefits provision, the plan that has *primary* responsibility always pays *first*. The rules for determining which plan pays benefits first are the same as described in [Coordination of Benefits](#).

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

If You Are Enrolled in the DMO

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

If You Continue to Work After Age 65

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

Claiming Healthcare Benefits

Claims should always be submitted to the primary plan first.

For Urgent Care Claims

If you file an urgent care claim, the Claims Administrator will make an initial benefit determination within 72 hours after they receive your properly completed claim form and all required documentation.

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

- Assuring the patient's life, health or ability to regain maximum function
or
- In the opinion of a physician with knowledge of the patient's medical condition, avoiding severe pain.

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

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

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

For Post Service Claims

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

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

Hospital Benefits

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

Laboratory Benefits

If you receive a bill from Moses, Wakefield, Einstein/Weiler or Quest for outpatient diagnostic and laboratory tests do not pay it. Call the Montefiore billing department or Quest, identify yourself as a registered nurse of Montefiore enrolled in the Registered Nurses Health Plan and instruct them to send the invoice to the Claims Administrator.

DMO Benefits

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

If you use an out-of-network dentist, you must file a claim for reimbursement. Submit the completed form to Aetna at the address shown on the form. Be sure to include all of the necessary documentation.

Other Benefits

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

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

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

Attach all necessary documentation to the form:

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

Prescription Drugs

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

Claims Administration

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

To claim benefits for these covered expenses:	Claims should be submitted as follows:
Healthcare Expenses	
– Medical	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 866.236.6748
– Dental	Empire BlueCross BlueShield Dental Benefits Programs P.O. Box 791 Minneapolis, MN 55440-0791
Dental Maintenance Organization (DMO)	Aetna Dental™ P.O. Box 14094 Lexington, KY 40512-4094
Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 800.631.7780
All claims must be submitted within 18-months of the date care was provided. Otherwise, no benefits will be paid.	

You must include the Name and Membership ID Number of the Montefiore Registered Nurse on *all* claim forms submitted to the Claims Administrator – including claim forms provided to you by your physician and claims for covered expenses incurred by a dependent. Otherwise, your claim cannot be processed or paid.

You should complete a *separate* claim form for each person for whom benefits are being requested. If another plan is the primary payer, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form.

Other Important Information About Your Healthcare Benefits

Termination of Healthcare Coverage

Healthcare coverage ends at the end of the month in which:

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

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

- For your dependent children – at the end of the calendar year
- For your spouse or domestic partner – at the end of the calendar month.

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

General Notice of Cobra Continuation Coverage Rights

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

If healthcare coverage stops as a result of:

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

. . . you and/or your qualified beneficiaries can individually elect to continue coverage under the Montefiore Medical and/or Dental options you had in effect at the time of the qualifying event.

Depending on the type of qualifying event, your spouse or qualified domestic partner, and eligible dependent children may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries.

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

Notifying the COBRA Administrator of Qualifying Events

You or your family members must notify Montefiore's HR-Benefits Office in writing if 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:

- You receive notice of your right to continue healthcare coverage

or

- The date healthcare coverage stops, if later.

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

Paying for COBRA Coverage

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

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

Duration of COBRA Coverage

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

If you are:	And lose healthcare coverage due to one of the qualifying events shown below:	You can choose continuation of healthcare coverage for up to:
an MMC RN	<ul style="list-style-type: none"> layoff, leave of absence (including military leave), or termination of employment (for reasons other than your gross misconduct) a reduction in your regularly scheduled hours 	18 months
	<ul style="list-style-type: none"> disability (at the time of termination of coverage or within the first 60 days of continuation coverage) 	29 months
a covered spouse or qualified domestic partner of an MMC RN	<ul style="list-style-type: none"> your spouse or domestic partner is on layoff, leave of absence, or terminates employment (for reasons other than gross misconduct) a reduction in your spouse or domestic partner's regularly scheduled hours 	18 months
	<ul style="list-style-type: none"> your spouse or domestic partner is disabled at termination of employment or within the first 60 days of continuation coverage 	29 months
	<ul style="list-style-type: none"> the death of your spouse or domestic partner your spouse or domestic partner is disabled divorce, legal separation, annulment or termination of a qualified domestic partnership 	36 months
a covered dependent child of an MMC RN	<ul style="list-style-type: none"> your parent is on layoff, leave of absence or terminates employment (for reasons other than gross misconduct) a reduction in your parent's regularly scheduled hours 	18 months
	<ul style="list-style-type: none"> your parent is disabled at termination of employment or within the first 60 days of continuation coverage 	29 months
	<ul style="list-style-type: none"> the death of your parent your parents' divorce, legal separation, annulment or termination of a qualified domestic partnership you no longer qualify as a dependent for medical and dental coverage 	36 months
Note: In no case can COBRA coverage continue for more than 36 months, even if you experience multiple qualifying events.		

When the continuation period ends, healthcare benefits stop.

Continuation of healthcare coverage may be cut short if:

- You or your family members do not make all the required contributions on a timely basis
- or
- Montefiore terminates all health plans.

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

If You Have Questions

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

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

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

Keep Your Program Informed of Address Changes

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

HIV Coverage

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

Important Notice

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

This overview of HIPAA is intended to help you understand your rights and protection of personal information related to your health. Please review it carefully.

Key provisions of these privacy standards include:

- ***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.
- ***Limits on Use of Personal Medical Information*** – The privacy rule sets limits on how covered providers may use your identifiable health information. These limits do not restrict the ability of health care professionals to share any medical information needed for treatment. They do restrict its use for purposes not related to health care. Covered providers may use or share only the minimum amount of protected information needed for a particular purpose. In no case will a covered provider use or disclose your personal medical information which is genetic information for underwriting purposes. You must provide written authorization for the following medical information to be disclosed:
 - *Psychotherapy notes if maintained by the plan.*
 - Personal medical information for marketing purposes. For example, your written authorization will be required for the covered provider to share your medical information to promote health care products or services, alternative treatments, or provide appointment or treatment reminders. Your written authorization will not be required for prescription refill reminders, general health and wellness communications or communications about government or government-sponsored programs, such as eligibility for Medicare or Medicaid.
 - *Disclosures that constitute a sale of your personal medical information. A sale means that the covered entity receives direct or indirect remuneration in exchange for personal medical information. Your authorization is not required if remuneration for personal medical information is required to perform activities or provide service, such as research or for the services provided by the health information exchange.*

- Personal health information released to a life insurer, a bank, a marketing firm or another outside business for purposes not related to your health care.
- ***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.
- ***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.
- ***Complaints*** – You may file a formal complaint regarding Montefiore Medical Center privacy practices to:
 - Health Plan Privacy Officer
 - HR – Benefits Office
 - Montefiore Medical Center
 - 111 East 210th Street
 - Bronx, NY 10467-2490
 - Telephone: **1.914.378.6531**

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

If there is a breach of your unsecured personal medical information, you will be notified promptly.

Genetic Information Non-discrimination Act of 2008 (GINA)

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

Surcharge

New York State has imposed an 8.18% surcharge on certain medical expenses. Montefiore has made arrangements to pay this surcharge directly to the state. If you receive a bill that itemizes the surcharge, do not pay this charge. Notify the provider that Montefiore participates in the New York State Department of Health Public Goods Pool. It is important that you not make this payment since the Medical Center has already made this payment for you. The Claims Administrator will not reimburse you for this charge. If you have paid this surcharge, you should contact the provider for a refund. You can ask the Claims Administrator to send a letter to the provider confirming that the Claims Administrator has paid that surcharge to the state.

Subrogation

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

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

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

Qualified Medical Child Support Orders (QMCSOs)

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

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

Occupational Health Services (OHS)

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

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

HealthCare Employee Assistance Program

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

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

Care Guidance

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

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

Your PHN will help you:

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

Voluntary Pre-Notification

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

You should notify Care Guidance:

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

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

Flexible Spending Accounts

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

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

- Federal income tax
- Social Security tax (on your earnings below a certain level)
- Medicare tax
- and*
- State and local income taxes in many states, including New York and Connecticut (but not in New Jersey).

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Glossary of Key Terms

Annual Base Earnings – Your annual base rate of pay including any tax-deferred contributions you make to a qualified plan sponsored by Montefiore, for example, the Personal Voluntary Annuity (PVA) Plan, but excluding differentials, overtime pay, uniform allowances and any other forms of extra compensation.

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

Eligible Dependent Care Expenses – Those expenses listed in IRS Publication 503 as eligible for reimbursement and incurred to provide day care to your eligible dependents so that you and, if you are married, your spouse can work or look for work.

Eligible Dependents

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

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

WageWorks – The Claims Administrator for Flexible Spending Accounts.

Your Flexible Spending Accounts

Two Flexible Spending Accounts are available to you.

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

Only expenses incurred while you are making contributions to the Flexible Spending Accounts are eligible for reimbursement.

How Flexible Spending Accounts Save You Money

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

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

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

² The Social Security tax rate drops to 1.45% for earnings over the Social Security wage base, which for 2015 is \$118,500.

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

Your Contributions

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

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

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

Special Rules to Consider

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

- Once you establish a Healthcare Account, it cannot be canceled or reduced during the year.
- Once your contributions begin, the government will not allow them to be changed during the year unless you experience a qualified change in status. Whatever amount you select for either or both accounts must continue until year-end. Transfer of money between the two accounts is *not* permitted.
- To reduce the possibility of forfeitures, IRS rules permit you to apply eligible expenses incurred through March 15th against any remaining balance in your prior year's Healthcare Account.
- The Dependent Care Account operates on a calendar year basis. This means that eligible expenses you incur in one calendar year can only be paid with contributions you make in the same calendar year.
- If you are newly eligible or have a qualified change in status and enroll in a Healthcare or Dependent Care account during the year, only expenses incurred while you are making contributions to the Flexible Spending Accounts are eligible for reimbursement. You cannot obtain reimbursement for expenses incurred before your contributions begin or after they stop.
- The IRS requires that any amounts remaining in your account(s) after April 30th of the following year must be forfeited.

In return for a significant tax advantage when you use your FSA, the government prohibits Montefiore from returning unused FSA contributions. However, there is a four-month "grace period" that gives you until April 30th of the following year to submit claims for expenses up to your account balance. Keep in mind, however, that even with a small forfeiture you may still come out ahead using the Flexible Spending Accounts because of the tax savings.

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

Discrimination Testing

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

Eligible Healthcare Expenses

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

Subject to IRS rules, eligible healthcare expenses may include:

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

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

- Telephone – special equipment for the hearing impaired
- Television – audio display equipment for the hearing impaired
- Transportation and travel expenses for medical care
- Vaccinations and immunizations
- Vasectomy
- Vitamins, herbal supplements, natural medicines and nutritional supplements recommended for the treatment of a specific medical condition
- Weight loss programs for treatment of a specific disease diagnosed by a physician (i.e., obesity, hypertension or heart disease)
- Wheelchairs for the relief of sickness or disability, and not just to provide transportation to and from work
- Wig – if recommended by a physician for the mental health of a patient who has lost all of his/her hair as a result of disease.
- X-ray fees for medical reasons.

Letter of Medical Necessity

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

Products and services that may require a Letter of Medical Necessity (for treatment of a medical condition) are:

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

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

Healthcare Expenses Not Eligible

Expenses *not* eligible for reimbursement include:

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

Eligible Dependent Care Expenses

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

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

Subject to IRS rules, eligible dependent care expenses include:

- Before-school or after-school care for children under age 13
- Day care services provided in your home
- Day care services provided through an outside source, such as an individual, summer day camp or a day care center (if the center provides day care services for more than six persons, it must comply with all state and local laws).
- Pre-school, Nursery school or similar programs for children below the level of kindergarten.

Dependent Care Expenses Not Eligible

Dependent care expenses *not* eligible for reimbursement include:

- Care provided by someone you claim as a dependent on your federal income tax return, or your child under age 19
- Household services
- Institutional care, such as nursing home services for an elderly parent or grandparent
- Overnight summer camp
- Summer school and tutoring programs
- Transportation expenses to get to a day care provider outside of your home or for bringing a provider to your home
- Weekend or “evening out” babysitting.

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

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

Dependent Care Account Versus the Federal Tax Credit

You are eligible for a credit on your federal income taxes for dependent care expenses similar to those that can be reimbursed through the Dependent Care Account. You cannot use both methods to gain a “double” tax advantage on the same expenses. You can use one or the other; or, apply the tax credit to some expenses and use the Dependent Care Account for others. However, maximum expenses for the tax credit calculation (\$3,000 for one dependent, \$6,000 for two or more dependents beginning in 2003) are reduced dollar for dollar by reimbursements made through the Dependent Care Account.

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

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

Annual Limit

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

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

Dependent Care IRS Reporting Requirements

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

Claims Reimbursement

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

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

Claims Administrator
PO Box 14053
Lexington, KY 40511

Be sure to attach copies of all bills, Explanations of Benefits (EOBs), itemized vendor receipts and/or statements to the claim form. Canceled checks and other non-itemized receipts alone will not be accepted.

- Healthcare attachments must include the name of the patient, the date the service was rendered, the name of the service provider, the type of service(s) and the amount charged.
- Dependent Care attachments must include the name, address and taxpayer identification number of your dependent care provider, the name of the eligible dependent, the date the services were rendered, the type of service(s) and the amount charged.

If you request reimbursement of an amount greater than your:

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

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

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

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

Other Important Information

If You Leave Montefiore

Healthcare Account – COBRA Continuation

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

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

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

Dependent Care Account

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

In Case of Your Death

Healthcare Account

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

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

Dependent Care Account

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

Life Insurance

Life insurance is designed to pay a benefit to your beneficiary if you die from any cause while coverage is in effect. The benefit provides protection all during your active career with Montefiore, as long as you remain eligible.

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Glossary of Key Terms

Annual Base Earnings – Your annual base rate of pay including any tax-deferred contributions you make to a qualified plan sponsored by Montefiore, for example, the Personal Voluntary Annuity (PVA) Plan, but excluding differentials, overtime pay, uniform allowances and any other forms of extra compensation.

Beneficiary – The person or persons you name to receive your 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 Life Insurance benefit if you die. Your contingent beneficiary receives your 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.

Imputed Income – The IRS assigns a value to the premium of any Montefiore-provided Basic Non-contributory Life Insurance coverage over \$50,000. This premium value (determined by IRS tables) is called imputed income and added to your taxable income on your W-2 Form.

Total Disability – An illness, injury or pregnancy lasting at least six months that prevents you from performing the material duties of any job for which you are or could reasonably become qualified based on your training, education or experience.

Basic Non-contributory Coverage

While you are an active, eligible registered nurse, your Basic Non-contributory Life Insurance depends on your annual base earnings as shown in the following table.

Once you reach age 70, your benefits are reduced – see [“If You Work Past Age 70”](#).

Annual Base Earnings:	Basic Non-contributory Life Insurance Amount:
\$40,000 or more	\$60,000
\$34,000 but less than \$40,000	\$55,000
\$32,000 but less than \$34,000	\$49,000
\$30,000 but less than \$32,000	\$46,000
\$28,000 but less than \$30,000	\$43,000
\$26,000 but less than \$28,000	\$40,000
\$24,000 but less than \$26,000	\$37,000
\$22,000 but less than \$24,000	\$34,000
\$20,000 but less than \$22,000	\$31,000
\$18,000 but less than \$20,000	\$28,000
\$16,000 but less than \$18,000	\$25,000
\$14,000 but less than \$16,000	\$22,000
\$12,000 but less than \$14,000	\$19,000
\$10,000 but less than \$12,000	\$16,000
Less than \$10,000	\$10,000

Additional Contributory Coverage

You can also purchase Additional Life Insurance coverage equal to:

- 25% of your basic coverage
 - 50% of your basic coverage
 - 75% of your basic coverage
- or*
- 100% of your basic coverage.

For example, if your annual base earnings are \$40,000 and you purchase additional coverage equal to 50% of your Basic Life Insurance – your total coverage would be:

Basic Non-contributory Life Insurance	\$60,000
<i>plus</i>	+
Additional Contributory Life Insurance	<u>\$30,000</u>
Total Coverage	\$90,000

Evidence of Insurability

In some cases, evidence of insurability must be submitted to the insurance company before coverage can take effect. Evidence of insurability is required if:

- You waive coverage and later decide to elect Additional Contributory Life Insurance for the first time more than 30 days of your initial eligibility (your coverage will not become effective until you receive written notification from the insurance company that your coverage has been approved)
- During the fall annual election period you elect Additional Contributory Life Insurance which is greater than your current coverage (your current coverage will remain in effect until you receive written notification from the insurance company that your additional coverage has been approved – or if your application for higher coverage is denied).

If Your Annual Base Earnings Change

Your Life Insurance (both Basic and Additional Contributory) will change on the day your annual base earnings change to another earnings bracket – if you are actively at work on that day. Otherwise, any change in Life Insurance becomes effective on the day you return to active employment and work your regularly scheduled hours.

Imputed Income

As required by the IRS, the premium value of any Montefiore-provided Basic Non-contributory Life Insurance coverage over \$50,000 is subject to imputed income. This value – determined by IRS tables based on your age and the amount of coverage over \$50,000 – is added to your taxable income on your W-2 Form. Montefiore is required by federal law to withhold FICA taxes on this imputed income each pay period. The overall tax impact is relatively small compared to the additional protection your life insurance coverage provides.

Payment of Benefits

The full amount of your Life Insurance – Basic and any approved Additional 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 approval by the State Insurance Department of New York, in the following order of priority:

- Spouse or domestic partner, if any, otherwise
- Divided equally among your child(ren), if any, otherwise
- Divided equally between your parent(s), if any, otherwise
- Divided equally between your sibling(s), if any, otherwise
- Your estate, if you have no surviving family members, as indicated above.

Accelerated Benefit

Your Life Insurance coverage includes an “accelerated benefit.” This feature permits you to request payment of up to 75% of your Life Insurance 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 \$60,000 of Life Insurance and request and receive an accelerated benefit of \$45,000. Following your death, your beneficiary will receive \$15,000.

The accelerated benefit you receive is currently not subject to tax.

If You Become Disabled

If you are an active registered nurse and become [totally disabled](#) before age 70, the full amount of your Life Insurance will continue in effect at no cost to you for as long as you remain disabled – up to the date you reach age 70 – provided you submit periodic proof of your continuing disability to the insurance company. The insurance company has the right to request that a physician of their choice examine you. When Life Insurance stops, you can convert coverage by applying for an individual policy and paying the required premium.

If You Work Past Age 70

If you work past age 70, your Life Insurance will continue— but your coverage amount will gradually reduce as shown in the following table. Each change in coverage will take place on the January 1 coinciding with or next following the date that reach the ages shown below.

Age:	Percentage of Age 69 Coverage That Continues:
70	90%
71	81%
72	73%
73	66%
74	60%
75 – 79	39%
80 and older	27%

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 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

Termination of Coverage

Life Insurance coverage stops on the date:

- The group policy is terminated
- You are no longer eligible
- You leave Montefiore for any reason, except total disability
- A work stoppage begins (coverage will be reinstated on the day you return and work your regularly scheduled hours).

Additional Contributory Life Insurance coverage also stops if you fail to make the required contributions.

Extension of Coverage

Your Life Insurance coverage continues under the following circumstances:

- While you are receiving your full salary from Montefiore including sick pay (any required contributions will be deducted from your pay)
- When you are unable to work because of a sickness, injury or pregnancy while you are kept on Montefiore's payroll (any required contributions will be deducted from your pay; if your pay is insufficient, you must arrange to prepay any required contributions)
- During the first month of an approved, unpaid personal leave of absence, military leave or while on temporary layoff (if the leave is longer than one month, you must prepay the full premium from the first day of the leave)
- If you are eligible for and take an approved sabbatical, Life Insurance coverage will continue for up to one year if:
 - You continue to have the required contributions deducted from your pay while you are on sabbatical
 - You send in a monthly payment on an after-tax basis
 - or*
 - You prepay the required contributions (before-tax).

If you do not elect to continue Life Insurance coverage while on sabbatical and return to work for Montefiore, you will be required to provide satisfactory evidence of insurability at your own expense before Life Insurance coverage will begin again.

Conversion Privilege

If Life Insurance coverage ends, you can convert all or part of it to an individual group term life insurance policy without having to provide EOI to the insurance company. To convert your coverage, your completed conversion application and payment for the first quarter's premiums must be mailed to the insurance company and postmarked within 31 days after coverage ends.

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 were otherwise eligible.

If your Life Insurance is reduced – either due to your age or your retirement – you can convert the difference between the full amount of your Life Insurance and the amount in effect after the reduction to an individual policy.

Assignment of Life Insurance

Any assignment of your 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 Life Insurance to provide collateral for a loan.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) Insurance pays a benefit:

➤ To *you*, if you lose a limb, sight, speech, hearing or suffer paralysis or a coma

or

➤ To your beneficiary, if you die

...as the result of a covered accident. In case of your accidental death, AD&D benefits are paid in addition to your Life Insurance benefits.

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Glossary of Key Terms

Beneficiary – The person or persons you name to receive your Accidental Death and Dismemberment (AD&D) 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 AD&D Insurance benefit if you die. Your contingent beneficiary receives your AD&D 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.

Covered Accident – A sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place and results in a covered loss.

Total Disability – An illness, injury or pregnancy lasting at least six months that prevents you from performing the material duties of any job for which you are or could reasonably become qualified based on your training, education or experience.

Coverage Amount

If you are an eligible Registered Nurse, your AD&D Insurance is \$60,000.

Payment of Benefits

The *full* amount of your AD&D Insurance will be paid to your beneficiary if you die or remain in a coma as the result of and within 365 days after a covered accident. Payment will be made in one lump sum.

If you lose a limb, sight, speech, hearing or suffer paralysis as the result of and within 365 days of a covered accident, you will receive a percentage of your AD&D coverage as follows.

If You Lose:	You Receive:
Both hands, both feet and/or sight of both eyes	100% of your AD&D Insurance
Quadriplegia	100% of your AD&D Insurance
One hand and one foot	100% of your AD&D Insurance
One hand or one foot and sight of one eye	100% of your AD&D Insurance
Loss of speech and hearing	100% of your AD&D Insurance
One hand or one foot or sight of one eye	50% of your AD&D Insurance
Paraplegia or Hemiplegia	50% of your AD&D Insurance
Loss of speech or hearing	50% of your AD&D Insurance
Loss of thumb and index finger or all four fingers of the same hand or all toes of the same foot	25% of your AD&D Insurance
Uniplegia	25% of your AD&D Insurance

For payment of benefits:

- *Loss of hand or foot* – means severance through or above the wrist or ankle
- *Loss of eyesight* – means entire and irrecoverable loss.
- *Loss of hearing* – means the entire and irrecoverable loss of hearing in both ears
- *Loss of speech* – means the entire and irrecoverable loss of speech.
- *Loss of thumb and index finger* – means the complete severance through or above the metacarpophalangeal joint.
- *Plegia*- means permanent, complete and irreversible paralysis of one or more limbs which must continue for twelve consecutive months.

No more than 100% of your coverage will be paid for all losses resulting from one accident.

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

- Spouse or domestic partner, if any, otherwise
- Divided equally among your child(ren), if any, otherwise
- Divided equally between your parent(s), if any, otherwise
- Divided equally between your siblings(s), if any, otherwise
- Your estate, if you have no surviving family members, as indicated above.

If You Work Past Age 70

If you work past age 70, your AD&D Insurance will continue but your coverage amount will gradually reduce as shown in the following table. Each change in coverage will take place on the January 1 coinciding with or next following the date you reach the ages shown below. Coverage reductions are the same as for Life Insurance.

Age:	Percentage of Age 69 Coverage That Continues:
70	90%
71	81%
72	73%
73	66%
74	60%
75 – 79	39%
80 and older	27%

Exclusions

AD&D benefits are *not payable* for any loss caused by, contributed to, or resulting from:

- Illness or disease; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease
- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury
- War or any act of war, declared or undeclared
- Involvement in any type of active military service, except when participating in the Reserve or National Guard for less than sixty days on inactive duty status in such activities as attending regularly scheduled or routine training, attending Service School, taking part in any other authorized inactive duty training, parade, or exhibition, as well as traveling to and from each activity
- Riding in or getting into or out of:
 - Any conveyance used for tests, experimental purposes, or in a race or speed test
 - Any aircraft engaged in specialized aviation activity (as defined in the policy)
- Riding in, getting into or out of any aircraft **unless**:
 - (a) you are a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as a passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation
and
 - (b) the aircraft is not owned, leased, controlled or operated by or on behalf of Montefiore, you, or any other insured person, a member of your or any other insured person's household, or any other employer of the associate, unless a specific written agreement has been obtained from the insurance company
- Participation in the commission or attempted commission of a felony
- The deliberate ingestion of a poison, fume, noxious chemical substance; or the use of a prescription drug unless taken as prescribed by a physician; or a non-prescription drug unless taken in accordance with its directions.

Claiming Benefits

To claim AD&D benefits you, in case of dismemberment, or your beneficiary, in case of your death, should contact Montefiore's HR-Benefits Office. They will help you or your beneficiary complete the appropriate forms. Benefits cannot be paid until the forms and necessary proof of loss have been submitted to the insurance company. All claims must be filed within 90 days after a loss – or as soon thereafter as is reasonably possible.

Other Important Information

Termination of Coverage

AD&D Insurance stops on the date:

- The group policy is terminated
- You are no longer eligible
- You fail to make any required contribution
- You leave Montefiore for any reason, including retirement.

Basic AD&D coverage also stops if you become totally disabled, even if you qualify for continuing Life Insurance. Basic AD&D Insurance cannot be converted to individual coverage.

You can port your Voluntary AD&D Insurance (up to a maximum of \$250,000) but, you must apply for portability and pay the first premium within 31 days after your coverage ends.

In the event of your accidental death or injury during the 31-day conversion period – whether or not you had applied for portability – you or your beneficiary will receive the amount of Voluntary AD&D Insurance you had the right to port.

Eligibility for portability ends at age 70.

Business Travel Accident Insurance (BTA)

This Plan pays a benefit:

➤ To your beneficiary, if you die

or

➤ To you, if you lose sight, limb, speech or hearing

.... as the result of a covered accident while traveling on Montefiore business.

BTA Insurance is paid in addition to your Life and Accidental Death and Dismemberment (AD&D) Insurance benefits.

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Glossary of Key Terms

Business Trip – Means that you are on assignment by or working at the direction of Montefiore on Montefiore business. A business trip begins when you leave your home or regular place of employment (whichever occurs last) to begin the business trip and ends when you return home or to Montefiore – whichever is first.

Coverage Amounts

Montefiore provides BTA Insurance equal to four times your annual base salary (minimum benefit \$100,000/maximum benefit \$1,000,000) at no cost to you.

Payment of Benefits

BTA Insurance is paid if you die or lose sight or a limb as the result of and within 365 days of a covered accident while on a business trip provided the loss:

- Is caused solely and directly by accidental bodily injury
- Occurs independently of other causes
- and*
- Occurs while you are covered under this Plan.

The *full* amount of your BTA Insurance is paid to your beneficiary in a lump sum if you die as a result of and within 365 days of a covered accident.

If you lose sight or a limb as the result of and within 365 days of a covered accident, you will receive a percentage of your BTA Insurance, as follows.

If you lose:	You receive:
Both hands, both feet or sight of both eyes	100% of your BTA Insurance
One hand and one foot	100% of your BTA Insurance
Speech and hearing	100% of your BTA Insurance
One hand or one foot and sight of one eye	100% of your BTA Insurance
One hand or one foot or sight of one eye	50% of your BTA Insurance
Speech or hearing	50% of your BTA Insurance
Thumb and index finger of same hand	25% of your BTA Insurance

For payment of benefits:

- *Loss of hand or foot* – means severance through or above the wrist or ankle
- *Loss of eyesight* – means entire and irrecoverable loss
- *Loss of hearing* – means entire and irrecoverable loss of hearing in both ears
- *Loss of speech* – means entire and irrecoverable loss of speech
- *Loss of thumb and index finger* – means the complete severance through or above the metacarpophalangeal joint.

No more than 100% of your coverage will be paid for all losses resulting from one accident. BTA Insurance benefits are paid *in addition* to your Life and AD&D Insurance benefits.

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

- Spouse or domestic partner, if any, otherwise
- Divided equally among your child(ren), if any, otherwise
- Divided equally between your parent(s), if any, otherwise
- Divided equally between your sibling(s), if any, otherwise
- Your estate, if you have no surviving family members, as indicated above.

Exclusions

BTA Insurance will not pay benefits for losses caused by:

- Accidents that occur at any time other than while on a business trip (for example, while on vacation, layoff, leave of absence, disability absence, unpaid sabbatical and commuting to and from work)
- A sickness or pregnancy existing at the time of the accident
- Flying in any aircraft owned or operated by Montefiore
- Injury sustained as a result of riding as a passenger, pilot, operator or member of the crew of any vehicle or device for aerial navigation
- Suicide, attempted suicide or intentionally self-inflicted injuries
- War or act of war, whether declared or undeclared, whether civil or international and any substantial armed conflict with organized forces of a military nature
- Your participation in a crime
- Your alcoholism or drug addiction.

Claiming Benefits

Your beneficiary or you in case of dismemberment should contact Montefiore's HR-Benefits Office immediately after a loss. Claim forms and other assistance will be provided. Proof of loss must be provided within 90 days after the loss or as soon as possible thereafter if proof cannot reasonably be provided within the 90-day period. Claims not filed within these time limits will be denied and no benefits will be paid.

Termination of Coverage

BTA Insurance stops when the first of the following occurs:

- The group policy is terminated
 - You are no longer eligible for the plan
 - The end of the period for which your premium has been paid
- or*
- Your employment with Montefiore terminates for any reason.

BTA Insurance also stops if you go on an unpaid sabbatical, a paid or unpaid leave of absence, while you are absent from work due to an illness or injury and while you are on vacation. Coverage will resume again once you return to active employment and work your regularly scheduled hours.

BTA Insurance cannot be converted to individual coverage.

Disability Benefits

Disability benefits continue part or all of your pay if you are ill or injured and unable to work. Coverage is provided by the following:

- Short-term Disability (STD) Benefits – including Paid Sick Leave, New York State Disability and Supplementary Sick Pay
- Intermediate-term Disability
and
- The Long-term Disability (LTD) Plan.

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Short-term Disability

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

Short-term Disability benefits are provided by:

- Paid Sick Leave
- New York State Disability
- and*
- Supplementary Sick Pay.

Paid Sick Leave

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

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

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

For Full-time Registered Nurses

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

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

For Part-time Registered Nurses

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

Paid Sick Leave Accruals

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

Sick Leave “Buy Back”

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

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

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

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

Sick Time Bank

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

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

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

New York State Disability

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

Supplementary Sick Pay

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

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

Duration of Payments

Once they begin, Short-term Disability benefits continue for as long as you remain disabled – but not beyond 26 weeks from the date that you first became disabled.

Intermediate-term Disability

Once you become eligible and as long as it is determined that you continue to be disabled, Intermediate-term Disability benefits begin after Short-term Disability benefits stop.

Plan Benefits

Intermediate-term Disability benefits continue two-thirds of your base salary up to a maximum benefit of \$170 a week.

Duration of Payments

Intermediate-term Disability benefits continue for a maximum of 26 weeks.

Long-term Disability (LTD) Plan

This Plan helps replace part of your income if you become disabled as a result of sickness, accidental injury or pregnancy, for more than 365 days. To qualify for benefits, you must be under the regular care of a physician and be:

- Unable to perform the majority of the substantial and material duties of your own occupation (the occupation you perform regularly for Montefiore Medical Center before your disability begins).

or

- Unable to earn more than 80% of your indexed predisability earnings while working in any occupation or your own occupation on a modified basis.

After the first two years of receiving LTD benefits, you may continue to qualify for benefits if:

- You cannot perform the majority of the substantial and material duties of any gainful occupation for which you are or may reasonably become qualified based on education, training, or experience.

or

- You are performing the substantial and material duties of your own occupation or any occupation on a modified basis and are unable to earn more than 50% of your indexed predisability earnings.

The loss of a professional or occupational license or certification does not, in itself, determine disability.

Predisability Earnings

Monthly predisability earnings are your monthly wages in effect prior to the date you become disabled. Wages include your contributions to the Personal Voluntary Annuity 403(b) Plan, Flexible Spending Accounts and before-tax contributions you make to the Montefiore Benefits Program. Earnings do not include commissions, bonuses, tips, differential pay, housing and/or car allowance or overtime pay.

Indexed Predisability Earnings

During your first year of disability, your indexed predisability earnings and your predisability earnings are the same. On each March 1, following the date you become disabled, your indexed predisability earnings will be increased by the average rate of increase in the Consumer Price Index (CPI) during the preceding calendar year up to an annual maximum of 10%. There will never be a decrease in your indexed predisability earnings, even if there is a drop in the CPI. When you return to work under a [Work Incentive Period](#), indexed predisability earnings are used to determine the reduction, if any, in LTD benefits due to income from other sources; they are *not* used to provide increases in LTD benefit payments.

Elimination Period

The Elimination Period is the length of time of continuous partial or total disability which must be satisfied before you are eligible to receive benefits. Your benefit payment period begins after you have been disabled for 365 days.

If you recover and return to work:

- During the elimination period and become disabled again, your elimination period will pick up at the point where it was left off when you recovered. You have 730 days to satisfy the 365-day elimination period. The days that you are not disabled will not count toward your elimination period.
- For six months or less – after you have been receiving LTD benefits – and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

Plan Benefits

When you are unable to work in any capacity during the benefit payment period, your monthly benefit equals your primary monthly benefit less income from other sources. If you are not eligible for income from other sources, the LTD Plan provides the full benefit.

LTD Plan benefits continue:

- 50% of your predisability earnings
- Up to a maximum benefit of \$430 a month. The minimum LTD Plan benefit is \$85 a month.

Income from Other Sources

Your monthly LTD benefit will be reduced by any income you receive from the following sources:

- Any sick pay or other salary continuation (but not vacation pay) paid to you by the Medical Center
- Any amount you, your spouse or your children receive from Social Security or a similar act or plan due to your disability or your retirement
- Any amount you receive or are eligible to receive due to your disability from:
 - Workers' Compensation or similar law, including amounts for partial or total disability, whether permanent or temporary
 - Any group insurance coverage other than group credit insurance or group mortgage disability insurance
 - Any state unemployment compensation disability benefit law or state disability income benefit law
- Any disability retirement benefits you elect to receive from a defined benefit pension plan to which Montefiore contributed on your behalf
- Renewal commissions received from the policyholder
- Severance pay
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above.

Income from other sources does not include:

- Amounts you receive:
 - For reimbursement of hospital, medical or surgical expenses
 - As an award or settlement for medical benefits, rehabilitation benefits, income benefits for fatal or scheduled injuries involving loss or loss of use of specific body members
 - From a tax-sheltered annuity (e.g., the Personal Voluntary Annuity 403(b) Plan), non-qualified deferred compensation plan, Individual Retirement Account (IRA), Keogh (HR-10) Plan or a retirement plan under a Professional Service Corporation with respect to principals or shareholders
- or*
- Which represent reasonable attorney's fees incurred in connection with the claim for income from other sources
- Benefits from any individual disability insurance policy
- Military or Veterans Administration disability or retirement payments
- Cost of living increases from any income from other sources which become effective while you are disabled and eligible to receive payments (this exception does not apply to any increases in earnings if you work while disabled)
- Social Security or pension plan benefits being received before your disability begins.

Because your LTD benefits are coordinated with income from other sources, you must notify the Claims Administrator promptly if you receive or expect to receive any awards or settlements. You must notify the Claims Administrator of the nature of the other income benefits, the amounts received, the periods to which the other income benefits apply and the duration of the other income benefits if paid in installments.

Work Incentive Period

If you are able to work while disabled, you may still be eligible to receive a disability benefit. If you are working during the benefit payment period, your monthly benefit for the 12 month work incentive period is the lesser of:

- 100% of your indexed predisability earnings, less income from other sources, less current earnings;
- or*
- Your primary monthly benefit, less income from other sources.

After the work incentive period, your monthly benefit equals your primary monthly benefit less income from other sources and multiplied by your income loss percentage. Your income loss percentage is your indexed predisability earnings less any current earnings divided by your indexed predisability earnings.

Rehabilitation Services and Benefits

Rehabilitation Services

While disabled, you may qualify to participate in a rehabilitation plan. The rehabilitation staff will work with you, your physician(s), Montefiore and its insurance carrier to create an individual rehabilitation plan to assist you in returning to work.

Rehabilitation assistance may include:

- Coordination of medical services
- Vocational and employment assessment
- Purchasing adaptive equipment
- Business/financial planning
- Retraining for a new occupation
- Educational expenses.

If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own occupation, preventive rehabilitation services may be offered.

Reasonable Accommodation Benefit

If you are able to work while you are disabled and if you make changes in your work environment or the way your job is performed that would allow you to return to work and perform the essential functions of your job, you may be eligible to receive a Reasonable Accommodation Benefit. After written authorization, the LTD Plan will reimburse you the cost of tools, equipment, furniture or other changes to the worksite or environment (not to exceed \$2,000) that would allow you to return to work.

Survivor Benefits

A survivor benefit equal to *three times* your monthly maximum LTD benefit is paid to your eligible survivors in a lump sum following your death, if you die while receiving LTD benefits.

Eligible survivors are:

- Your spouse or domestic partner
- Your unmarried dependent children
- Your parents
- Any person providing the care and support of any of the above
- Your estate, if you have no surviving family members, as indicated above.

In case of your death, your eligible survivors should notify the HR-Benefits Office immediately.

Social Security Benefits

In case of disability, you may be eligible for primary and/or family Social Security disability benefits. If you become totally disabled, you are required to apply for Social Security benefits as soon as possible. If the Social Security Administration denies your claim, you will be required to follow the Social Security Administration's claims review process. If your claim is denied a second time, and the insurance company agrees to pay the costs, you must request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

If you do not apply for Social Security disability benefits, the Insurance Company reserves the right to reduce your LTD benefits using an estimate of what you would have received from Social Security had you applied.

Exclusions

The LTD Plan does not cover disabilities caused or contributed to by:

- Intentionally self-inflicted injury
- Active participation in a riot
- Participation in a felony
- War or act of war whether declared or not, any armed conflict whether civil or international, and any substantial armed conflict between organized forces of a military nature
- A disability caused by a *pre-existing condition* unless you have been continuously insured under the group policy for at least 12 months
- A new or continuing disability that begins after your benefit payment period has ended, but you have not returned to active work.

Pre-existing Condition

A pre-existing condition is a sickness, injury or pregnancy, including all related conditions and complications, for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition at any time during the three months immediately before you became covered by the LTD Plan you:

Disabilities caused by a pre-existing condition that occur during your first 12 months of coverage under this Plan are *not* covered. However, that 12-month period will be reduced by any time you were covered under another employer's LTD Plan, if no more than 60 consecutive days elapsed between the dates your prior LTD coverage ended and coverage under this LTD Plan began.

Pre-existing condition exclusions also apply to benefit increases due to:

- Policy amendments
- Changes in earnings of 25% or greater.

Duration of LTD Benefits

How long LTD benefits continue depends on your age when you become disabled. If your disability begins before age 60, benefits continue until the later of age 65 or 5 years after your benefit payment period begins. If you are age 70 or over when you become disabled, LTD benefits continue for one year.

Age at Disability	Maximum Benefit Period
Age 60 through 64	5 years
Age 65 through 69	To age 70, but not less than 1 year
Age 70 and over	1 year

Your disability benefits will end when you:

- Recover
- Reach the maximum payment period
- Cease to be under the regular and appropriate care of a physician
- Fail to provide any required proof of disability
- Fail to submit to a required medical examination
- Fail to report income from other sources, or any other required earnings information
- Fail to pursue Social Security disability benefits or Workers' Compensation benefits
- Die, except for any survivor benefits that may be payable.

Treatment of Mental Health Conditions

If your disability is the result of a mental disorder, LTD benefits are paid for up to a lifetime maximum of 24 months – unless you are hospitalized when the 24-month period ends. If you are in the hospital when benefits would ordinarily end, benefits will continue during your confinement and up to 60 days following your release from the hospital. If you are hospitalized again during the 60-day period following hospitalization for at least ten consecutive days, benefits will continue for the duration of the second hospital confinement and the 60 day period following your release from the hospital.

Other Benefits during Disability

While you are receiving Paid Sick Leave or Short-term Disability benefits, your Medical, Dental, Flexible Spending Accounts and Life Insurance benefits continue, as long as your salary is sufficient to cover any required contributions, or you arrange to prepay your contributions for these coverages.

AD&D Insurance and the Dependent Care Flexible Spending Account benefits end when Short-term Disability benefits end.

The following table shows how your coverages may be continued after Short-term Disability benefits end.

To Continue This Coverage After Short-term Disability Benefits Stop:	You Must:
Medical Coverage*	
<ul style="list-style-type: none"> For you and your covered family members at the time you became disabled, if you remain disabled and your LTD claim is not approved 	<ul style="list-style-type: none"> Elect Continuation Coverage (COBRA) and pay the required premium.
<ul style="list-style-type: none"> For you and your covered family members at the time you became disabled, if you remain disabled and your LTD claim is approved 	<ul style="list-style-type: none"> Your coverage will continue , at no cost to you, for you and your covered family members subject to plan eligibility provisions up to 24 months from your date of disability or until you become eligible for Medicare, if earlier. When coverage stops, you may elect Continuation Coverage (COBRA). Generally, to become eligible for Medicare, you must have received Social Security disability benefits for 24 months, or have permanent kidney failure. You must apply for Social Security disability benefits.
Dental coverage for you and your family members	Elect Continuation Coverage (COBRA) and pay the required premium.
Healthcare Flexible Spending Account	Make contributions on an after-tax basis for the rest of that calendar year.
Life Insurance	Convert to an individual insurance policy if you are age 70 or older when you become disabled. If you are under age 70 when you become disabled, Life Insurance continues at no cost to you until you reach age 70, then you can convert to an individual policy.
<p>* If you contract the HIV virus as a result of your employment with Montefiore and become eligible for Workers' Compensation benefits, Medical coverage for you will continue until you become eligible for Medicare – but in no case longer than 29 months. When Medical coverage stops, you can elect COBRA if you are not eligible for Medicare for whatever time remains under the COBRA provisions.</p>	

Claiming Benefits

Short-term and/or Intermediate-term Disability

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

Supplementary Sick Pay and New York State Disability benefits begin on the eighth consecutive calendar day of disability and continue for up to 26 weeks.

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

Long-term Disability

If you expect to remain totally disabled for more than 365 days, you or a family member should contact Montefiore's HR-Benefits Office to begin the application process for LTD benefits. LTD benefits cannot begin until the forms and necessary proof of disability have been submitted to and approved by the insurance company. You will need documentation showing that:

- You became disabled while covered under the Plan from a condition that the Plan does not exclude *and*
- Your disability is expected to continue for more than 365 days and you have been under the regular care of a physician.

You will also be asked to submit documentation of any other income payments that you are or may become entitled to receive.

When you file a claim, you agree to permit the insurance company to consult with your physician and to review any related medical records. The insurance company may also require that you be examined by a physician of their choice, at their expense.

Claims for LTD benefits must be submitted as soon as possible, but no later than 120 days after the end of the 365-day elimination period. Otherwise, benefits will not be paid.

Principal is the claims review fiduciary for the Long-term Disability 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.

Termination of Coverage

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

LTD coverage ends on the date:

- The group policy is terminated
- You are no longer actively at work for any reason unless:
 - You are receiving full salary (including sick pay)
 - You are satisfying the elimination period before LTD benefits begin
 - You are on a leave of absence of 30 days or less
 - You are on an approved FMLA leave and continue to pay the required monthly contribution on a timely basis
- You are no longer eligible for the Plan
- You become a full-time member of the armed forces of any country
- You go on a temporary layoff or work stoppage
- You terminate your employment with Montefiore for any reason.

If the group policy is terminated while you are receiving LTD Plan payments, your benefits will not be affected in any way.

LTD insurance cannot be converted to individual coverage.

Continuation of Coverage

If you continue to pay the premiums, your insurance may continue under the following circumstances:

- For an unpaid personal or educational leave of absence, through the end of the month following the date the leave begins.
- For an unpaid medical (non-maternity) leave of absence, to the end of the month following 6 months from the date the leave begins.
- For a maternity leave, to the end of the month following 4 months from the date the leave begins.
- For an unpaid military leave of absence, to the end of the month following 6 months from the date the leave begins.
- For layoff, up to 1 month.

ERISA Additional Information

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

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

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Plan Sponsor

The sponsor of all of the Plans in the Registered Nurses Benefits Program is:

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

Plan Administrator

The Plan Administrator for the Registered Nurses Benefits Program is:

Vice President, Human Resources
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467-2490
914.378.6550

Employer Identification Number

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

Claim Denials and Appeals

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

The claims review fiduciary has the discretionary authority to interpret the coverages and the insurance policy 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:
RN Health Plan	Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 866.236.6748 www.empireblue.com/montefiore/
RN Dental Benefits	Empire BlueCross BlueShield Dental Benefits Programs P.O. Box 791 Minneapolis, MN 55440-0791
Prescription Drugs	Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 800.631.7780 www.express-scripts.com
Dental Maintenance Organization (DMO)	Aetna Dental™ P.O. Box 14094 Lexington, KY 40512-4094 800.843.3661 www.aetna.com

For These Covered Expenses:	Claim Denials Are Received From And Appeals Should Be Directed To:
Flexible Spending Accounts	WageWorks PO Box 14053 Lexington, KY 40511 877.924.3967 www.wageworks.com
Life Insurance	Principal 711 High Street Des Moines, IA 50392-2840 800.245.1522
Accidental Death And Dismemberment Insurance	OneBeacon Insurance Company Accident & Health Claim PO Box 1009 Morristown, NJ 07962-1009 866.583.2233
Business Travel Accident	First Reliance Standard Life Insurance Company 153 East 53 rd Street, Suite 4950 New York, NY 10022 800.882.8700
Paid Sick Leave, Supplementary Sick Pay and Intermediate Term Disability	Montefiore Medical Center 111 East 210th Street Bronx, NY 10467-2490
Long-term Disability	Principal Life Insurance Company Attn: Group Life & Disability Claims Department Des Moines, IA 50392-0002 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 insurance company 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 insurance company 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 insurance company 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 insurance company will notify you of the decision within 30 days after receipt of your appeal.

If your appeal involves a post-service claim, the insurance company 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 insurance company 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 insurance company has the authority to make final decisions with respect to paying claims under the Medical Plan.

If you believe that you have been improperly denied a benefit from the Plan after making full use of the claims and appeals procedure, you may serve legal process on the Plan Administrator.

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 insurance company.

Union Agreement

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

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

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

Administrative Information

Official Plan Name	Plan Administrator/Insurance Company	Plan Number	Plan Funding
Montefiore Medical Center Health Benefits Plan for Registered Nurses	For Registered Nurses Health Plan and Registered Nurses Dental Benefits Empire BlueCross BlueShield PO Box 1407, Church Street Station New York, NY 10008-1407 866.236.6748	505	Registered Nurse and Montefiore contributions
	For Prescription Drug Program: Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417-2603 800.631.7780		Registered Nurse and Montefiore contributions
	For Health Care Flexible Spending Account: WageWorks PO Box 14053 Lexington, KY 40511 877.924.3967		Registered Nurse contributions
The Montefiore Medical Center Multi-benefit Cafeteria Plan	<i>For Life Insurance:</i> Principal 711 High Street Des Moines, IA 50392-2840 800-245-1522	511	Registered Nurse and Montefiore contributions
	<i>For AD&D Insurance:</i> OneBeacon Insurance Company Accident & Health Claim PO Box 1009 Morristown, NJ 07962-1009 866.583.2233		Montefiore contributions
	For Dependent Care Flexible Spending Account: WageWorks PO Box 14053 Lexington, KY 40511 877.924.3967		Registered Nurse contributions
	For Dental Maintenance Organization: Aetna (DMO) 99 Park Avenue New York, NY 10016 800.843.3661		Registered Nurse and Montefiore contributions

Official Plan Name	Plan Administrator/Insurance Company	Plan Number	Plan Funding
Montefiore Medical Center Insured Benefit Plan	For Business Travel Accident Insurance: First Reliance Standard Life Insurance Company 153 East 53 rd Street, Suite 4950 New York, NY 10022 800.882.8700	508	Montefiore contributions
	For Long-term Disability: Principal Life Insurance Company Attn: Group Life & Disability Claims Department Des Moines, IA 50392-0002 800.245.1522		
	For Supplementary Sick Pay: Montefiore Medical Center 111 East 210 Street Bronx, NY 10467	583	Montefiore contributions
	For Paid Sick Leave: Montefiore Medical Center 111 East 210 Street Bronx, NY 10467	N/A	Montefiore contributions
	For Intermediate-term Disability: Montefiore Medical Center 111 East 210 Street Bronx, NY 10467		

Plan Type and Plan Year

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

	Plan Type	Plan Year
Medical	Welfare providing healthcare benefits	January 1 to December 31
Dental	Welfare providing dental benefits	January 1 to December 31
Prescription Drug	Welfare providing prescription drug benefits	January 1 to December 31
Flexible Spending Accounts	Welfare providing tax-free reimbursement of eligible health and dependent care expenses	January 1 to December 31
Life and AD&D Insurance	Welfare providing life and accidental death and dismemberment benefits	January 1 to December 31
Business Travel Accident Insurance	Welfare providing business travel life and accident benefits	January 1 to December 31
Paid Sick Leave	Welfare providing short term disability benefits	January 1 to December 31
Supplementary Sick Pay	Welfare providing short term disability benefits	January 1 to December 31
Intermediate-term Disability	Welfare providing intermediate term disability benefits	January 1 to December 31
Long-term Disability	Welfare providing long term disability benefits	January 1 to December 31

Plan Documents

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

Plan Continuation

Subject to collective bargaining, Montefiore expects and intends to continue the Medical, Dental, Flexible Spending Accounts, Life Insurance and Accidental Death and Dismemberment Insurance, Business Travel Accident and Disability Plans indefinitely, but reserves the right to change, modify or terminate the Plans, in whole or in part, at any time and for any reason subject to collective bargaining. If Medical and/or Dental benefits are terminated, you will not have the right to any benefits or have any further rights – other than payment of covered expenses you had incurred before the coverage terminated.

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

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plans, including the Trust agreement and administrative service contracts, Plan descriptions and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration EBSA (formerly the Pension and Welfare Benefits Administration).
- Obtain upon written request to the Plan Administrator, copies of all documents governing the operation of the Plans, including the Trust agreement and administrative service contracts, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of each Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report
- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

- When you lose health coverage
 - When you become entitled to elect COBRA continuation coverage
 - When your COBRA continuation coverage ends
 - At any time before losing healthcare coverage
- or*
- Up to 24 months after losing healthcare coverage.

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

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

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

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the appropriate fiduciary and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the appropriate fiduciary to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the appropriate fiduciary.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning a medical child support order or the status of a qualified domestic relations order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse a plan's money, or, if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about these Plans, you should contact the appropriate fiduciary. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of EBSA, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at **800.998.7542**.