

HSBP BENEFITS ENROLLMENT

You and your eligible dependents are entitled to supplemental coverage through the HSBP. Each employer makes a contribution to the Plan on behalf of each House Staff Officer on its payroll. Therefore, the supplemental coverage, as described in this booklet, is available without cost to you.

HSBP BENEFITS ENROLLMENT

In order to enroll for the HSBP benefits for yourself and your eligible dependents, YOU MUST COMPLETE AN ENROLLMENT CARD obtained from the Benefits Plan Office. (Domestic partners of participants employed at an HHC hospital or at WMC do not have to be enrolled with the City of New York to be eligible for supplemental HSBP benefits. However, you must complete the HSBP Eligibility Statement for Domestic Partnership. This information is kept strictly confidential).

BASIC HEALTH INSURANCE

You are also eligible for basic health insurance, which is provided by the hospital at which you are employed, under the contract between the Committee of Interns and Residents (CIR) and your employer. Enrollment for this basic insurance is your responsibility; you should check with the hospital's personnel office at the beginning of each contract year to verify that your insurance is still in effect.

The basic health insurance plan is considered your primary insurance and insures not only you, but also your eligible dependents (i.e., your spouse or [in New York State only] your domestic partner, and eligible dependent children). In order to be covered for this insurance, there is one requirement: You must enroll for this insurance by signing an authorization form for yourself and your eligible dependents at the personnel office of the hospital at which you are employed. Domestic partners of participants employed in a Health and Hospitals Corporation hospital can be covered for basic benefits. Domestic partners must be registered with the City of New York in order to be eligible for basic benefits. Participants employed at Westchester Medical Center cannot enroll their domestic partners for basic benefits. However, the domestic partners of participants employed at either WMC or an HHC hospital can be eligible for supplemental HSBP benefits.

RULES FOR ENROLLMENT

As noted previously, you must complete an **Enrollment Card** in order to be eligible for benefits from the House Staff Benefits Plan for yourself and your eligible dependents and submit it before the end of one month from your date of hire. If you do not complete an Enrollment Card and select a dental plan for yourself and your eligible dependents, you will be penalized by not being able to access all the dental services available to those residents who enrolled in a timely manner.

DENTAL PENALTY

The penalties for failure to enroll within one month of residency include access only to preventative and some basic services in the first 12 months of enrollment. You and your eligible dependents will not be able to utilize major services such as crowns or complex molar root canal therapy until after your first 12 months of enrollment. You will not be able to use the orthodontic services until after you have been enrolled for 24 months. **We urge you to complete your Dental Application and to select your dental plan as soon as possible.**

HSBP Insured Benefits

Most HSBP benefits are insured by the Plan itself. They are: Accidental Dismemberment, Dental (supplemental), Supplemental Major Medical, Short-Term Disability, Supplemental Obstetrical,

Newborn Benefit, Childbirth Education, Outpatient Psychiatric Benefit, Substance Abuse Counseling and Treatment, Optical Benefits, Prescription Drug Benefits, Smoking Cessation, Conference Reimbursement for Health and Hospitals Corporation (HHC) and Conference, Books and Medical Equipment Benefits for Westchester Medical Center (WMC) residents.

Guardian Life Insurance Company insures the following benefits: Dental Benefit, Long-Term Disability, Life Insurance (Term) and Life Insurance (Term) for Your Spouse or Registered Domestic Partner. IdentityTruth insures the Identity Theft Protection Benefit.

PROCEDURE FOR FILING CLAIMS

1. Make sure your enrollment card is on file and up-to-date.
2. Obtain claim forms before you have services rendered.
3. Provide all the information requested on the claim forms.
4. Enclose all bills and relevant documents with the claim forms.
5. Keep copies of all material sent to the Benefits Plan office
6. Submit the completed forms to the Benefits Plan office promptly.

Forms and information can be obtained from the Benefits Plan office. Call or write House Staff Benefits Plan, 520 Eighth Avenue, Suite 1200, New York, New York 10018, Telephone: (212) 356-8180, Fax: (212) 356-8181, E-Mail: benefits@cirseiu.org. You can download claim forms from the website: www.cirseiu.org/benefits

ELIGIBILITY

You become eligible for benefits based on the day you go on your employer's payroll. HSBP covers only employees of the New York City Health and Hospitals Corporation (HHC), CIR and HSBP employers, Westchester Medical Center and for selected benefits at Cambridge Health Alliance, Doctor's Medical Center of Modesto (Stanislaus); Highland General Hospital (Alameda County Medical Center); Santa Clara Valley Medical Center; LA County. If, during a rotation away from any of the above hospitals, you switch from that hospital's payroll to the rotation hospital's payroll, you should be aware that your HSBP benefits cease for such period and you cannot submit a claim for any costs incurred during such period. Your HSBP benefits coverage resumes on the day you return to your original payroll.

ELIGIBLE DEPENDENTS

Eligible dependents are your spouse (unless legally separated) and your unmarried dependent children under 19 years of age. Unmarried children up to 26 years of age are also eligible provided they are full-time students in an educational institution and depend wholly upon you for support and maintenance. Proof from the educational institution of the full time status is required every semester.

Benefits are also available to HSBP participants' domestic partners and their dependent children where the participant is employed by an employer located within the State of New York.

Eligible domestic partners and their dependent children are covered for all benefits listed in the "Schedule of Benefits" under the titles "For Dependent Spouses/Domestic Partners" and "For Employees and Dependents." To be eligible for this benefit, a participant and domestic partner must complete the "HSBP Eligibility Statement for Domestic Partnership" which requires proof of domestic partnership. The fair market value of the premium for insurance benefits provided to domestic partners and their dependent children will be reported to the IRS as taxable income to the HSBP participant. The reportable income amount has been about \$1,000.

Stepchildren and foster children may be included as dependents if they depend upon you for support and maintenance. You should refer to the Coordination of Benefits section of this booklet to see when benefits are payable under this Plan.

When your coverage initially starts, if a dependent (except a newborn child) is confined for medical care or treatment in any institution or at home, that dependent will not be covered until given a final release by the attending physician from such confinement.

No one will be eligible as a dependent while covered as an employee under the HSBP or the Voluntary Hospital House Staff Benefits Plan, or while in military service.

A child who is physically or mentally incapable of self-support may, upon attaining age 19, have coverage continued while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. Dependents who were eligible for coverage beyond age 19 who have since been disqualified will again be eligible should they become disabled and incapable of self-support. To continue a child under these provisions, proof of incapacity must be received within 31 days after the child's coverage would otherwise terminate. Additional proof may be required from time to time.

Qualified Medical Child Support Orders (QMCSO's)

According to federal law, a qualified Medical Child Support Order, or QMCSO, is an order of a court or state administrative agency resulting from a divorce or legal separation that has been received by the Plan and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

The QMCSO may not require that a Plan provide any benefit that is not otherwise provided under the Plan, but, if the employee is a Plan Participant and provides coverage for dependent children, the QMCSO may require that Plan to provide coverage for the employee's dependent children and to accept contributions for that coverage from a parent who is not a Plan participant.

The QMCSO may also require the Plan to pay benefits on account of expenses incurred by or on behalf of the dependent children either to the Health Care Provider who rendered the services or to the custodial parent of the dependent children. If the HSBP office or its designee determines that it has received a QMCSO, and if coverage of the dependent children is provided by the Plan, it will pay benefits on account of expenses incurred by or on behalf of the dependent children as required by that QMCSO. If the employee and spouse are divorced, and if a court or state administrative agency has issued an order with respect to health care coverage for any of the employee's dependent children, the HSBP office or its designee will determine if the court or administrative agency order is a QMCSO as defined by federal law, and that determination will be binding on the employee.

Coverage of a dependent child under a QMCSO will terminate when coverage of the employee terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if that right applies.

Change in Family Status

Once you are covered under the Plan, it is necessary that you notify the Benefits office promptly of any changes in the number of your dependents that occur because of marriage, birth, adoption, death, divorce or legal separation. If you are adding dependents, be sure to indicate their dates of birth and relationship on a new enrollment card and dental application. This Plan does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. These benefits are provided through the hospital where you are employed, under the CIR contract.

IMPORTANT

Notify the Benefits Office promptly when:

- You get married.
- You change your address.
- A child is born or adopted.
- A death occurs in your family.
- You are divorced or legally separated.
- You want to change your Life Insurance beneficiary.
- You acquire or change your Social Security Number.

Please Note: Failure to do so may affect your benefit coverage.

Family and/or Medical Leave

If you have completed 12 months of employment, you are entitled by law to up to 12 weeks each year of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth or adoption or placement with you for adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. While you are officially on such a Family or Medical Leave, you can keep your medical and dental coverage in effect during that period.

You are generally eligible for a Family or Medical Leave if you work at a location where at least 50 employees are employed by the employer within 75 miles.

Your plan coverage will remain until the end of the leave, provided your employer properly grants the leave and makes the required notification to the Board of Trustees.

Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that Leave, your medical and dental coverage will be reinstated without any additional limits or restrictions imposed on account of your Leave. This is also true for any of your dependents who were covered by the Plan at the time you took your Leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that Leave will apply to you and your dependents in the same way they apply to all other employees and their dependents.

To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Human Resources Department. To find out more about your benefits during Family and Medical Leave, contact the Plan Office.

Leave for Military Service

In accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, if you go into active military service for up to 31 days, you will continue your medical and dental coverage, up to 31 days.

If you go into active military service for more than 31 days, you may be able to continue your medical and dental coverage at your own expense for up to 18 months. See the following information on Continuation of Coverage (COBRA) for a full explanation of when and how these circumstances may apply to your medical or dental coverage.

You will not retain coverage for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to work with an employer that participates in the Plan's collectively bargained agreement, provided that you return to employment within:

- ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or

- fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

Questions regarding your entitlement to this leave should be referred to your employer. Questions regarding the continuation of medical and dental coverage should be referred to the Plan Office.

Termination of Coverage: When Coverage Ends

Your coverage ends on the earliest of the last day of the month in which:

- your employment ends; or
- you are no longer eligible to participate in the Plan.

Coverage of your covered dependents ends on the last day of the month in which:

- your own coverage ends; or
- your covered spouse/domestic partner or dependent children no longer meet the definition of spouse/domestic partner or dependent children.

Extension and Continuation of Coverage

Your Plan does not provide benefits for any medical or dental expenses incurred after coverage ends. However, under certain circumstances:

- Your medical and dental coverage may be extended for certain expenses incurred after coverage ends if you are totally disabled and receiving disability benefits through the Plan.

CONTINUATION OF BENEFITS WHILE YOU ARE DISABLED

Continuation of Benefits

If you go off payroll because of disability, you continue to be eligible for up to twelve (12) months coverage for all HSBP benefits if you are collecting disability benefits from the Plan. In addition, the Plan will reimburse you up to \$1,500 toward the cost of continuing your basic health coverage for twelve months on a direct payment basis (paid receipts required)

**CONTINUATION COVERAGE RIGHTS UNDER COBRA
COBRA AT-A-GLANCE**

COBRA Coverage May Continue For:	If the Following Event Occurs and Coverage is Lost:	Maximum Length of COBRA Coverage:
<p><i>You and Your Eligible Dependents.</i></p> <p><i>Call or E-Mail the Benefits Plan office for information regarding COBRA and Domestic Partners.</i></p> <p><i>Phone: 212-356-8180 or benefits@cirseiu.org</i></p>	<ul style="list-style-type: none"> • Your employment ends (for example, you resign) for any reason except gross misconduct. • Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Plan's welfare benefits program. 	<p>18 months (29 months if you or your eligible dependent is disabled).</p>
	<ul style="list-style-type: none"> • You die. • You are divorced or legally separated. • Your child(ren) no longer qualifies as an eligible dependent under the Plan. 	<p>36 months.</p>

CONTINUATION OF COVERAGE (COBRA)

Certificate of Creditable Coverage

When your coverage ends, you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time you and/or your dependents were covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law. This certificate may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents under the new group health plan or health insurance policy. Call or email the Benefits Plan office for information regarding COBRA and Domestic Partners.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for you and/or your covered dependent(s) has ended. This certificate will also be provided once the Benefits Plan Office receives a request for this certificate, provided that the Benefits Plan Office receives the request within two years after the later of the date your coverage under this Plan has ended or the date your COBRA coverage has ended.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered dependents) elect COBRA coverage, another certificate will be sent to you (or them if COBRA coverage is provided only to them) by first class mail shortly after the COBRA coverage ends for any reasons.

Please address all requests for certificates of Creditable Coverage to:

**House Staff Benefits Plan Office
520 Eighth Avenue - Suite 1200
New York, New York 10018**

COBRA MODEL GENERAL (INITIAL) NOTICE

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA ****

Introduction: You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Benefits Plan Office. The Plan may also provide an extension of benefits in certain cases of disability. Please contact the Plan Office if you are disabled for more information on your eligibility for such an extension.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced (including if you fail to work sufficient hours in a designated work period necessary to maintain plan eligibility), or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Plan office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, the employer must notify the Plan office of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Plan office within 60 days of the date that the qualified beneficiary would lose coverage after the qualifying event. You must provide this notice to the Plan office in writing at the address at the end of this notice. You may use the Plan's "COBRA Notice Form for Covered Employees and qualified Beneficiaries" to provide the notice. You may obtain a copy of this form from the Benefits Plan office.

Alternatively, you may send a letter to the Plan containing the following information: your name, the event for which you are providing notice, and the date of the event along with a copy of the supporting documentation (e.g., a copy of the first and last page of the divorce decree or a copy of a child's birth certificate or other proof of age).

How Is COBRA Coverage Provided?

Once the Benefits Plan office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months for spouses and dependents who are qualified beneficiaries.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

(1) Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefits Plan office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice must be sent no later than 60 days after the later of (1) the date of the disability determination by the Social Security Administration; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would lose coverage under the plan due to the qualifying event and before the end of the 18-month COBRA period. You must also provide a copy of the Social Security Administration Determination along with your notice.

You must also provide the Plan with a notice of a Social Security Administration determination if you are no longer disabled. That notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you are no longer disabled.

(2) Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family who are qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan.

Notice of the second qualifying event must be provided to the Benefits Plan office in writing. You may use the Fund's "COBRA Notice Form for Covered Employees and qualified Beneficiaries" to provide notice to the Plan. You may obtain a copy of this form from the Benefits Plan office.

Alternatively, you may send a letter to the Plan containing the following information: your name, for which of events you are providing notice, and the date of the event along with a copy of the supporting documentation (e.g., a copy of the first and last page of the divorce decree, a copy of a child's birth certificate or other proof of age, a copy of the employee's death certificate or a copy of the SSA disability determination). You must send the Notice no later than 60 days after the later of (1) the date of the relevant second qualifying event; or (2) the date upon which coverage would be lost under the plan as a result of the qualifying event.

This extension may be available to the spouse and any dependent children (if they are qualified beneficiaries) receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. Medicare entitlement is not a qualifying event under this plan because it does not result in loss of coverage. As a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Benefits Plan office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Plan office.

Plan Contact Information

The House Staff Benefits Plan Office is responsible for the administration of COBRA Continuation Coverage and can be reached at the address below:

**House Staff Benefits Plan
520 Eighth Avenue
Suite 1200
New York, NY 10018-4181
(212) 356-8180**