HOUSE STAFF BENEFITS PLAN
(HSBP)

NORTHERN CALIFORNIA HOSPITALS
ALAMEDA COUNTY MEDICAL CENTER
SANTA CLARA MEDICAL CENTER
VALLEY CONSORTIUM FOR MEDICAL EDUCATION

SUMMARY PLAN DESCRIPTION (SPD) & PLAN DOCUMENT
House Staff Benefits Plan
of the
Committee of Interns and Residents

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NORTHERN CALIFORNIA HOSPITALS
HOUSE STAFF BENEFITS PLAN

June 1, 2017

Dear Northern California employee:

We are pleased to present you with a booklet which describes the benefits available to you through the House Staff Benefits Plan (HSBP) of the Committee of Interns and Residents (CIR).

HSBP (the Plan) is an employee benefit trust fund, financed by contributions fixed by the Collective Bargaining or other written agreements, and administered by a Board of Trustees designated by CIR pursuant to an Agreement and Declaration of Trust (Trust Agreement) which may be amended from time to time. The Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted this plan of benefits described in this Summary Plan Description (SPD) which also serves as the Plan Document. Under the Trust Agreement and this SPD / Plan Document, the Trustees may, at their discretion, revise, discontinue, improve, reduce, modify or make changes in the plan, the types and amounts of benefits provided the coverage and eligibility provisions, conditions and rules, at any time. Any question(s) of interpretation, construction, application, or enforcement of the terms of the plan and this SPD / Plan Document, and all determinations on the benefit claims and appeals, are subject to the discretion of the Board of Trustees, whose determinations are final and binding.

The HSBP is currently funded by employers such as the New York City Health plus Hospitals (NYC H+H), Westchester Medical Center, Cambridge Health Alliance, CIR and HSBP employers, Modesto/Valley Consortium for Medical Education, Highland General Hospital (Alameda County Medical Center), Santa Clara Valley Medical Center, and Los Angeles County Hospitals. The HSBP receives its funds pursuant to the terms of the contract negotiated by CIR on your behalf. The contracts require your employer to make contributions to the Plan at a fixed rate per House Staff Officer.

This booklet describes the benefits to which you are entitled, eligibility guidelines, rules and regulations and the procedures to follow in order to obtain benefits and information.

We urge you to read this booklet carefully and retain it for future reference. We ensure you that HSBP will provide you with valuable benefits.

If you have any questions regarding HSBP, please call or write to the Plan Office.

Sincerely,

Eve Kellner, DO
Chair of the Board of Trustees
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GENERAL PLAN INFORMATION

This booklet describes the supplemental benefits provided to you through the House Staff Benefits Plan (HSBP). The benefits provided for Northern California residents are:
- Supplemental Short Term Disability
- Long Term Disability
- QI/Patient Safety Educational Benefits

IMPORTANT NOTICE

This booklet describes your benefits and this also serves as the Plan Document. Do not rely on statements made by individuals. The only authorized information concerning your benefits must be in writing from the Board of Trustees acting in their official capacity and whose sole decision regarding benefits is final. If you have any questions regarding your benefits, write to the Plan Manager and you will receive a written response.

While they have no current intention to do so, the Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under this Fund and (2) the eligibility rules, including those rules providing extended or accumulated eligibility, even if the eligibility has already been accumulated.
ELIGIBILITY

You become eligible for benefits based on the day you go on your employer’s payroll.

HSBP also covers employees of:
1. Cambridge Health Alliance
2. CIR and HSBP employers
3. LAC – Harbor: UCLA Medical Center
4. LAC + USC Medical Center
5. New York City Health + Hospitals
6. Westchester Medical Center

PLAN YEAR
- Plan Years are from July 1st to June 30th

WHEN DOES THE BENEFITS START?
- You become eligible for HSBP benefits based on the day you go on your employer’s payroll.
- You must work a minimum of 20 hours per week and contributions from your employer must be received by House Staff Benefits Plan on your behalf.
- Employees who are hired during the month of June will be eligible for benefits as of their date of hire, but the plan year will run from the date of hire through June 30th of the following year.

For Example:
- If you are hired on June 25, 2017 your plan year will be June 25, 2017 through June 30, 2018.
- The following year, your plan year will be July 1, 2018 through June 30, 2019.
- All other eligibility and termination rules will remain the same.
ROTATING OUT OFF NORTHERN CA PAYROLL
• If you rotate away from Northern CA payroll to a hospital not covered by HSBP, 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 an HSBP contributing employer payroll.

HOW TO ENROLL
• You have 30 days from your date of hire to give your Enrollment Form to your organizer.
• You must complete an Enrollment Form in order to be eligible for benefits provided from the House Staff Benefits Plan for yourself and your eligible dependents.
SUPPLEMENTAL SHORT TERM DISABILITY

(Self-Insured by the HSBP)

DEFINITION OF DISABILITY

“Disabled” means you are unable to work as a result of accidental bodily injuries, sickness, related medical condition, pregnancy or childbirth and are thereby prevented from performing the duties of your occupation and you are under the care of a legally licensed provider as defined by the State in which you work.

HOW DOES DISABILITY WORK?

The Plan provides you with income during a period of disability due to a non-occupational accident or illness.

- Supplemental Short-Term Disability Benefits are available for the employee only.
- The employee’s spouse and other dependents are not eligible for this benefit.
- Supplemental Short-Term Disability Benefits begin on the (60th) sixtieth day of a non-occupational disability.

Benefits are payable up to a maximum of 26 weeks during any one period of disability or until you are no longer disabled or no longer deemed disabled (i.e., the medical information does not substantiate the claim), if earlier.
WHAT IS THE MAXIMUM AMOUNT OF DISABILITY PAY?

Your Supplemental Short-Term Disability Benefits are equal to 70% of your weekly salary up to a maximum of $875 per week less any statutory benefits you receive (such as No-Fault wage replacement).

HOW TO APPLY?

• Members must apply for California short-term Disability Insurance during the 60-day waiting period.
• For information and claim forms, please click here: http://www.edd.ca.gov/disability/
• Obtain a claim form from the Benefits Plan Office and submit it to the Plan Office within 60 days of the start of your disability.
• The Benefits Plan Office will evaluate your claim and determine if benefits are payable and reserves the right to have a physician examine you (at the Plan’s expense) as often as is reasonable while a claim for benefits is pending or payable.

WHAT IS A DISABILITY CLAIM?

• A disability claim is a claim for benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant’s disability.
• You must be under the care of a legally licensed physician, dentist, psychologist, podiatrist, nurse-midwife or chiropractor for your claim to be considered.
• This provider must, when requested by the Fund, certify the following:
  o The scope of, the probable duration of, and all medical facts, to the best of his or her knowledge, about your disability.
WHEN ARE BENEFITS PAID?

- Benefits will be payable by this Plan on a bi-weekly basis during the continuation period for which you are disabled.
- Benefits begin on the 60th day of disability.
- No benefits will be paid prior to the 60th day of disability, nor for more than 26 weeks.
- Please note that sick leave benefits may be payable by the Hospital in which you work.
- If you receive payment for sick leave by your employer, any balance remaining after the payment for sick leave is made will be payable by this Plan under the Supplemental Short-Term Disability Benefits up to a maximum of $875 per week.

HOW LONG DOES IT TAKE TO GET APPROVED?

- The Benefits Plan Office will make a decision no more than 45 days after receipt of your properly filed claim.
- The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the Benefits Plan Office notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision.
- If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Benefits Plan Office receives your response to the request.
- If the Benefits Plan Office approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.
IF CLAIM IS DENIED

• If a claim for Disability Benefits is denied, you have the right to appeal.

APPEAL PROCESS FOR CALIFORNIA SDI

• For Benefits payable under California SDI, you should follow the instructions on the denial from the State in order to appeal the denial.

APPEAL PROCESS FOR SUPPLEMENTAL DISABILITY BENEFITS

• For appeals that pertain to the Supplemental Short-Term Disability benefits, please refer to the Plan’s claims and appeals procedures that are contained in the section entitled, “Claim Review and Claim Procedure”.
The following provides a quick guide to some of the Long Term Disability plan features which people want to know about most often. It’s not a complete description of your Long Term Disability plan, but a summary: For a complete description of the Long Term Disability Policy go to CIR website under your hospital.

**LTD ELIMINATION PERIOD (WAITING PERIOD)**

- For disability due to injury or illness the waiting period is 180 days. Note that Supplemental Short Term Disability may cover the first 26 weeks after the onset of illness or of an accident.

**GROSS MONTHLY BENEFIT CALCULATION**

- Long-Term Disability is 70% of your prior monthly earnings, rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $3,500 a month.

**Note:**
Guardian integrates your gross monthly benefit with certain other types of income you may receive. Read all of the terms of this plan to see what income Guardian integrates with, and how.

**MAXIMUM PAYMENT PERIOD**

- For a disability starting before the employee reaches age 60, the maximum payment period will last until the Social Security Normal Retirement Age.
- If the disability period starts when or after the employee reaches age 60, long term disability payments will continue based on a table.
For example, if the long term disability begins at age 60, the maximum period will be 5 years. Should the long term disability begin at age 69, the maximum period will be 1 year.

CLAIM PROVISIONS - FILING A CLAIM FOR BENEFITS

You must send the Benefits Office written notice of an injury or sickness for which you intend to file a long term disability claim within 30 days of the injury or start of the sickness for which a claim is being made. This notice should include your name and Social Security number and the plan number. You will be furnished with claim forms for filing proof of disability within 15 days of Guardian’s receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to the Benefits Office within a reasonable period of time.

If you are not furnished with the forms within the time stated, Guardian will accept a written description of the injury or sickness that is the basis for the claim in place of Guardian’s form. You must detail the nature and extent of the disability for which the claim is being made. If it is necessary to determine liability, as part of proof of loss, Guardian may require:

(a) certification of the extent and nature of your disability from all doctors who have treated you for the cause of your disability;
(b) certification of income from any other sources of income to which you may be entitled which may affect Guardian’s benefit payments;
(c) satisfactory evidence that you have applied for all benefits and payments from other income sources to which you may be entitled; and
(d) proof of any income from other sources that you have received. Guardian may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not
obtained can result in suspension or delay of long term disability benefit payments until such information or authorization is received by Guardian.

TIME LIMIT FOR THE FILING OF A CLAIM

Any claim not filed within a reasonable period of time following the end of the elimination period will be denied and no long term disability benefits will be payable unless Guardian receives written proof that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year retroactively from the date the claim is filed.

CONTINUED PROOF OF DISABILITY

Additional proof will be required. Written proof of your continued disability and doctor’s care must be provided to Guardian within 30 days of each date Guardian makes such request.

APPLICATION FOR OTHER INCOME REQUIRED

You must apply for any disability or retirement benefits with which Guardian integrates and which Guardian feels you may be entitled to receive. If such benefits are denied, Guardian requires you to apply for them again. You are required to continue to appeal all denials until: (a) you receive written notification from Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If Guardian feels that you are entitled to any of the benefits noted above, Guardian will: (a) assume you are receiving such benefits; and (b) integrate the gross monthly benefit with the estimated amount of such benefits payable to you and any applicable dependents on behalf of your disability. But Guardian does not do this if you sign Guardian’s agreement concerning benefits under which you promise: (a) to apply for any benefits Guardian integrates with; and (b) at Guardian’s request, to reapply for such
benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits. This paragraph does not apply to: (i) disability benefits from any compulsory benefit act or law; (ii) retirement benefits or retirement plan disability benefits under any other government plan which you receive as a result of your disability; and (iii) benefits from a Workers’ Compensation law, an occupational disease law, or any other act or law of like intent. If Guardian estimates them, they adjust your net monthly payments when they receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals Guardian requires. In the case of (b), if such adjustment shows Guardian underpaid you, they will pay you the full amount of the underpayment in a lump sum.

**COMPUTING YOUR NET MONTHLY BENEFIT FROM THIS PLAN**

Your net monthly benefit under this plan is your gross monthly benefit, as determined on your initial date of disability, integrated with any other income with which this plan integrates that you receive or are entitled to receive.

To compute your net monthly benefit under this plan: (a) determine your gross monthly benefit as shown above; and (b) from the gross monthly benefit, subtract the sum of all of the income with which Guardian integrates that you receive or are entitled to receive. The result is your net monthly benefit.

Your net monthly payment under this plan is your net monthly benefit determined above, reduced by 50% of any current monthly earnings you earn while disabled. If, during any month for which this plan pays benefits, the sum of the following: (a) your net monthly payment, as figured above; (b) the total amount of all other income with which this plan integrates that you receive or are entitled to receive; and (c) the amount of your current monthly earnings; is greater than the amount of your indexed prior monthly
earnings, your net monthly payment for that month will be further reduced by that portion in excess of 100% of your indexed prior monthly earnings. This will not apply during any period of time that you are an employee in a Guardian rehabilitation program, as described in this plan, and have signed a valid rehabilitation agreement with Guardian.

**WAIVER OF PREMIUM**

Guardian waives all premiums for your long term disability income insurance which fall due while you are entitled to receive a net monthly payment from this plan.

**REHABILITATION BENEFITS UNDER THIS PLAN**

If you are disabled under this plan and meet selection criteria as established by Guardian, you may be selected to enter into a rehabilitation agreement with Guardian. This agreement starts when: (a) Guardian informs you in writing that you have been accepted into the rehabilitation program; and (b) you agree in writing to participate in the rehabilitation program. You may be chosen for this program anytime you are disabled according to the terms of this plan. This includes during this plan’s elimination period. The exact terms of the rehabilitation agreement may be different for each employee, but all agreements will set forth a plan designed to return you to gainful employment. Gainful employment is employment that is appropriate to your disability, skills, experience and prior monthly earnings.

If you are chosen for a rehabilitation agreement, you will be entitled to an enhanced benefit based on 110% of the net monthly payment to which you would have been entitled had you not entered into the rehabilitation agreement. If you are chosen for such an agreement with Guardian, you will continue to be subject to all the terms of this plan. The enhanced benefit will start on the later of: (a) the effective date shown on the rehabilitation agreement; or (b) the date you complete the elimination period. Your eligibility for the enhanced benefit will extend until the
earliest of: (a) the date you are no longer disabled under this plan; (b) the date you earn or are able to earn at a rate of at least 80% of your indexed prior monthly earnings; (c) the date you die; (d) the end of this plan’s maximum payment period; (e) the date you violate any of the terms of the rehabilitation agreement; (f) the date you elect to end the rehabilitation program; or (g) the date the rehabilitation agreement expires.

If you end a rehabilitation agreement on a basis that is not agreeable to Guardian, you may be required to repay any benefits paid that are in excess of what this plan would have paid had you not participated in the rehabilitation agreement. There are additional advantages available to an employee who participates in a rehabilitation agreement as described above. For more information on these incentives and how you may become eligible to receive them, contact a Guardian rehabilitation specialist.

**SPECIAL LIMITATIONS MENTAL OR EMOTIONAL CONDITIONS, ALCOHOL ABUSE AND DRUG ABUSE**

If you are disabled, as defined by this plan, by a mental or emotional condition, alcohol abuse or drug abuse, Guardian limits this plan’s benefits. For the long term disability income coverage of this plan, a mental or emotional condition will include, but is not limited to, any of the following: bipolar affective disorder (manic depressive syndrome), schizophrenia, delusional (paranoid) disorders, psychotic disorders, depressive disorders, anxiety disorders, somatoform disorders (psychosomatic illness), eating disorders, mental illness.

For each disability due to a mental or emotional condition, alcohol or drug abuse, Guardian’s payments stop at the earliest of: (a) the date during any one period of disability that you have received 60 net monthly payments; (b) the end of the maximum payment period; or (c) the date disability ends. Also, payments will be limited to a total of 60 months in your lifetime for all disabilities contributed to, or caused by, any and all of the conditions shown
above. But, if at the end of benefit payments, you are being treated for the cause of your disability as an inpatient in a qualified institution for at least 14 consecutive days, Guardian extends the payments. Guardian extends them until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the maximum payment period; or (c) the date disability ends. By "qualified institution," Guardian means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your disability.

**PRE-EXISTING CONDITIONS**

A pre-existing condition is a sickness or injury, including all related conditions and complications, for which, in the three months before your insurance under this plan starts, you:

(a) Receive advice or treatment from a doctor; take prescribed drugs; or receive other medical care or treatment, including consultation with a doctor; or

(b) Exhibit symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. A pregnancy which exists on the date your insurance under this plan starts is also a pre-existing condition.

Guardian does not cover disability caused by such a condition until the later of:

(i) The day following the date you are insured under this plan for at least 12 consecutive months; and

(ii) The date benefit payments would otherwise start in the absence of this provision. Guardian does not cover any disability which begins before your insurance under this plan starts.
CONVERTING YOUR LONG TERM DISABILITY INSURANCE

ELIGIBILITY FOR CONVERSION

When your coverage under this group long term disability income plan ends, you may obtain a converted individual disability income policy, (hyper link for form) subject to the conditions below. You will be eligible for the converted individual disability income policy if you: (a) are not disabled under the terms of this plan; (b) have been covered under this plan (or a prior group disability income plan which this plan replaced) for at least 12 consecutive months immediately prior to the date your group coverage ends; (c) have successfully completed the residency program in which you were enrolled; and (d) apply to Guardian in writing within 45 days after the date on which your coverage under this plan ends.

By residency program, we mean a program of internship or residency in a medical specialty, accredited by the American Council for Graduate Medical Education. But you will not be eligible for a converted individual disability income policy if your group long term disability coverage ends because you: (a) fail to make a required contribution; (b) change to a class not eligible under this plan; (c) fail to complete a program of residency; (d) retire; or (e) because coverage ends for all persons or all persons in a class under this plan.

You do not have to provide evidence of good health to obtain the converted individual disability income policy, but you may be subject to other underwriting criteria. You must provide details concerning other disability income insurance in force or applied for, or for which you would become eligible under another plan within 45 days after the date that this group coverage ends. Guardian will not issue a converted individual disability income policy if such policy would result in your being over insured by our standards.
IS THERE A DEADLINE TO CONVERT TO THIS INDIVIDUAL DISABILITY INCOME POLICY

You must apply to Guardian in writing and pay any required premium to obtain a converted individual disability income policy. You must do this within 45 days of the date on which your group long term disability coverage ends. If you fail to apply to us in writing and pay any required premium within 45 days of the date your group long term disability coverage ends, you are no longer eligible to obtain a converted individual disability income policy.

EFFECTIVE DATE OF THE CONVERTED INDIVIDUAL DISABILITY INCOME POLICY

Your converted individual disability income policy, if issued, will be effective on the day your coverage under this group plan ends. The benefits, terms and conditions of the converted individual disability income policy will be those of the policy in use for such purpose in the state where you then live. These may be different from the benefits, terms and conditions of this group long term disability plan.

HOW MUCH WILL THIS INDIVIDUAL POLICY COST?

The premium for the converted individual disability income policy will be that in effect for your age and class of risk on the date the policy is issued.

CERTIFICATE AMENDMENT

This Long Term Disability plan is amended so that if a covered person is injured because of a third party’s wrongful act or negligence: we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice
our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery; we will be subrogated only to the extent of benefits paid by this plan because of that injury; and we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider: "Subrogation" means our right to recover any benefit payments made under this plan: because of an injury to a covered person caused by a third party’s wrongful act or negligence; and which the covered person later recovers from the third party or the third party’s insurer. "Third Party" means any person or organization other than Guardian, the employer or the covered person. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

**REQUIRED DISCLOSURE STATEMENT**

**For Group Plan No.: G –00348692**

This section is a short summary of the benefits this Plan provides. These benefits, including any exclusions and limitations, are fully explained in the HSBP Plan Documents. Please contact the Benefits Plan Office for more details. This plan provides the following health insurance benefits: Long Term Disability Income Insurance (defined as Disability Income Insurance by the New York State Insurance Department). This plan does not provideBasic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department. **Notice:** The above statements are not part of the group policy. The group policy alone determines the rights and duties of: (a) the employer to whom this plan is issued; (b) the policyholder (if other than such employer); (c) Guardian; and (d) any person covered by this plan.
Residents will be eligible to receive benefits of up to $3,000 per residency year to attend a U.S. Quality Initiatives and Patient Safety sponsored program that promotes the education and training of participants per plan year (July 1 – June 30).

Residents accessing this benefit are responsible for receiving time off (vacation or education leave time) to attend or participate in these educational/training opportunities.

**HOW ARE YOU SELECTED?**

Applications to participate in this benefit will be granted on an equitable basis based on completion of [QI Training & Education Application Form](#) and criteria developed by a Subcommittee of the HSBP Trustees.

**SUBMISSION RULES**

Prior to attending a conference, you will need to:

1. Apply at least 6 weeks prior to the conference date
2. Submit Curriculum Vitae (2 page maximum)
3. Personal Statement
4. Letter of support from a faculty member or mentor highlighting your leadership and patient safety engagement.
5. You must have a year left in your training

This scholarship does not cover any shift coverage to attend this event.

**SCHOLARSHIP COVERS**

1. Expenses related to registration
2. Lodging/hotel
3. Travel (i.e. plans, cabs, tolls, gas)
4. Meals
5. Poster(s)
PRESENT WHAT YOU LEARNED

- You have to include an explanation detailing how the applicant will present what they learned at the conference to their hospital colleagues at grand rounds, departmental presentations, or intern orientation.

RECOMMENDED CONFERENCES

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<tr>
<td>American Association of Medical Colleges (AAMC) Integrating Quality Conference</td>
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<tr>
<td>Association for Graduate Medical Education ACGME) Annual Conference</td>
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<tr>
<td>Agency for healthcare Quality and Research (AHRQ) Annual Conference</td>
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<td>American College of Medical Quality (ACMQ) Annual Meeting</td>
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<td>Annual Quality and Safety Educators Academy (QSEA)</td>
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<td>Beyond Flexner</td>
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<td>Institute for Healthcare Improvement (IHI)</td>
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<td>Lown Institute Annual Conference</td>
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<td>National Association for Health Quality (NAHQ) Annual Educational Conference</td>
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<td>Society of Teachers of Family Medicine (STFM) Annual Spring Conference</td>
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<td>SQUIRE International Conference</td>
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<td>Telluride Patient Safety Roundtable</td>
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The CIR/SEIU Benefits Plan may, at times, send Notices by e-mail to Plan participants at the email address provided by the participant. These Notices may include: information regarding open enrollment, plan amendments, your benefits, changes to your benefits, the benefits booklet (commonly known as Summary Plan Description or SPD), news and updates about your benefits, summary annual reports, newsletters, and other employee benefit Notices. Notices may also be available on the internet at www.cirseiu.org/benefits. The Plan may at times also send communications via first class mail.

The Plan’s use of electronic notices is governed by the following terms and conditions:

**Privacy**: By law, the Benefits Plan cannot use your information without your permission, except as described in our Notice of Privacy Practices located in the SPD.

**Contact Information**: You are responsible for ensuring the Plan has a current e-mail address for you at all times for electronic communications. If your e-mail address changes at any time, you must notify the Plan in writing or by sending an email to benefits@cirseiu.org. Any communication sent by the Plan to the most recent e-mail address on file will be deemed delivered to you.

**Opt-Out**: You may opt-out of receiving Notices electronically at any time by contacting the Plan in writing or by sending an email to benefits@cirseiu.org.

**Flexibility**: You have the right to request a paper copy of any electronic notice sent to you, free of charge.

**Hardware/Software Requirements**: Notices can be viewed on a computer system with an Internet Web browser capable of 128-bit

**Risks:** The Plan can't promise security and/or confidentiality when e-mailing. Although unlikely, it is possible an e-mail may be incorrectly shared or intercepted by someone other than the party to whom it was addressed. The Benefits Plan is not responsible for any such event.

**USERRA**

**Leave for Military Service**

A employee who enters military service will be provided continuation and reinstatement rights in accordance with the **Uniformed Services Employment and Reemployment Rights Act of 1994** (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

**What is USERRA?** USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee’s coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan
coverage for up to 24 months measured from the last day of the month in which the employee stopped working.

- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

**Duty to Notify the Plan:** The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

**Plan Offers Continuation Coverage:** Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Benefit Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.
Paying for USERRA Coverage:

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee’s eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan’s benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 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 8 hours), if the period of service was less than 31 days.

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

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee’s coverage will not be subject to any exclusion or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your employer.

Reinstatement of Coverage After Leaves of Absence:

- **If your coverage ends while you are on an approved leave of absence for family, medical or military leave,** your coverage will be reinstated on the day you return to active employment, if you return immediately after your leave of absence ends, subject to all accumulated Overall and Annual Maximum Benefits that were incurred prior to the leave of absence.

- **If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave,** your coverage will be reinstated on the day you return to active employment, if you return immediately after your leave of absence ends, subject to any Overall and Annual Maximum Plan Benefits that were incurred prior to the leave of absence.
Any period of any approved leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will **not** be counted as a Break in Coverage. Questions regarding your entitlement to an approved leave of absence and to the continuation of medical and dental coverage should be referred to your employer.

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**REVIEW OF CLAIM DENIAL**

If any claim is denied, you will receive a written notice stating the basis for the denial within 90 days after the submission of the claim. You will be entitled, upon written request, to a review of that claim decision.

Specific information regarding this review procedure can be obtained from the Benefits Plan Office.

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**RIGHT TO APPEAL**

- If a request for review results in an affirmation of the original denial, you have the right to submit a written appeal to the Board of Trustees.

- The Board will render a decision within 60 days after the receipt of the appeal unless special circumstances require an extension of time for processing.

- The Board’s decision shall be provided in writing and will include the specific reason(s) for the decision and specific reference(s) to the Plan provisions on which the decision is based.

- The decision of the Board of Trustees will be considered final.
STATEMENT OF EMPLOYEE RIGHTS

The House Staff Benefits Plan of the Committee of Interns and Residents is not covered by the Employee Retirement Income Security Act of 1974 (ERISA) because the House Staff Benefits Plan covers governmental employees. The Trustees have agreed, however, to accord employees the rights described below, which are typically available under ERISA funds. Employees will be entitled to:

- Examine, without charge, at the Plan Manager’s office all Plan documents, including insurance contracts, collective bargaining agreements and other documents such as annual reports and Plan descriptions.

ADDITIONAL PLAN INFORMATION

1. The House Staff Benefits Plan of the Committee of Interns and Residents is administered by a Board of Trustees, all of whom are appointed by the President of CIR and approved by the CIR Executive Board. The names of the Trustees are available from the Plan office, and their address for HSBP business is: House Staff Benefits Plan, 520 Eighth Avenue, Suite 1200, New York, New York 10018.

2. The name of the Plan Administrator is the Board of Trustees of the House Staff Benefits Plan of the Committee of Interns and Residents. The address of the Board of Trustees and HSBP office is:

   House Staff Benefits Plan  
   520 Eighth Avenue, Suite 1200  
   New York, New York 10018
The telephone number is (212) 356-8180. The fax number is (212) 356-8181. You may send e-mail to benefits@cirseiu.org.

3. The Employer Identification Number assigned by the Internal Revenue Service is EIN 13-6203291. The Plan number assigned by the Board of Trustees is 501. For purposes of maintaining the HSBP’s fiscal records, the year end date is December 31. The Board of Trustees has been designated as the agent for the service of legal process at its address above. Service of legal process may also be made upon a Plan Trustee.

4. Public employers make contributions to the Plan in accordance with Collective Bargaining Agreements between the Committee of Interns and Residents and themselves. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per year per House Staff Officer. Presently the New York City Health + Hospital (NYC H+H), Westchester Medical Center, California HSBP hospitals, Los Angeles County hospitals, and Cambridge Health Alliance are contributing employers.

5. Benefits are provided from the Plan’s assets, which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits for covered employees and eligible dependents and defraying reasonable administrative expenses. Some of these benefits are provided through insurance policies.

6. The Plan’s assets and reserves are held in custody by Smith Barney, and are invested by Stacey Braun Associates, Inc., 377 Broadway, New York, New York 10013. The Plan’s assets and reserves are invested in federal government securities and short-term investments.
7. The Plan’s requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are fully described in the eligibility section.

8. All of the types of benefits provided by the Plan are set forth in the Schedule of Benefits section of the Eligibility, Qualified Medical Child Support Order (QMCSO) and Family and/or Medical Leave section of this document. The complete terms of the life insurance benefits are set forth in the group insurance policies issued by Guardian Life Insurance Company of America. The complete terms of the Long-Term Disability benefits are set forth in the group insurance policy issued by the Guardian Life Insurance Company of America.

9. Employees and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employee organization is a sponsor of the Plan and, if so, the sponsor’s address. The Plan is maintained pursuant to Collective Bargaining Agreements. A copy of any such Agreement may be obtained by employees and beneficiaries upon written request to the Plan Administrator, and is available for examination by employees and beneficiaries.

10. The Plan is a welfare plan and a group health plan.