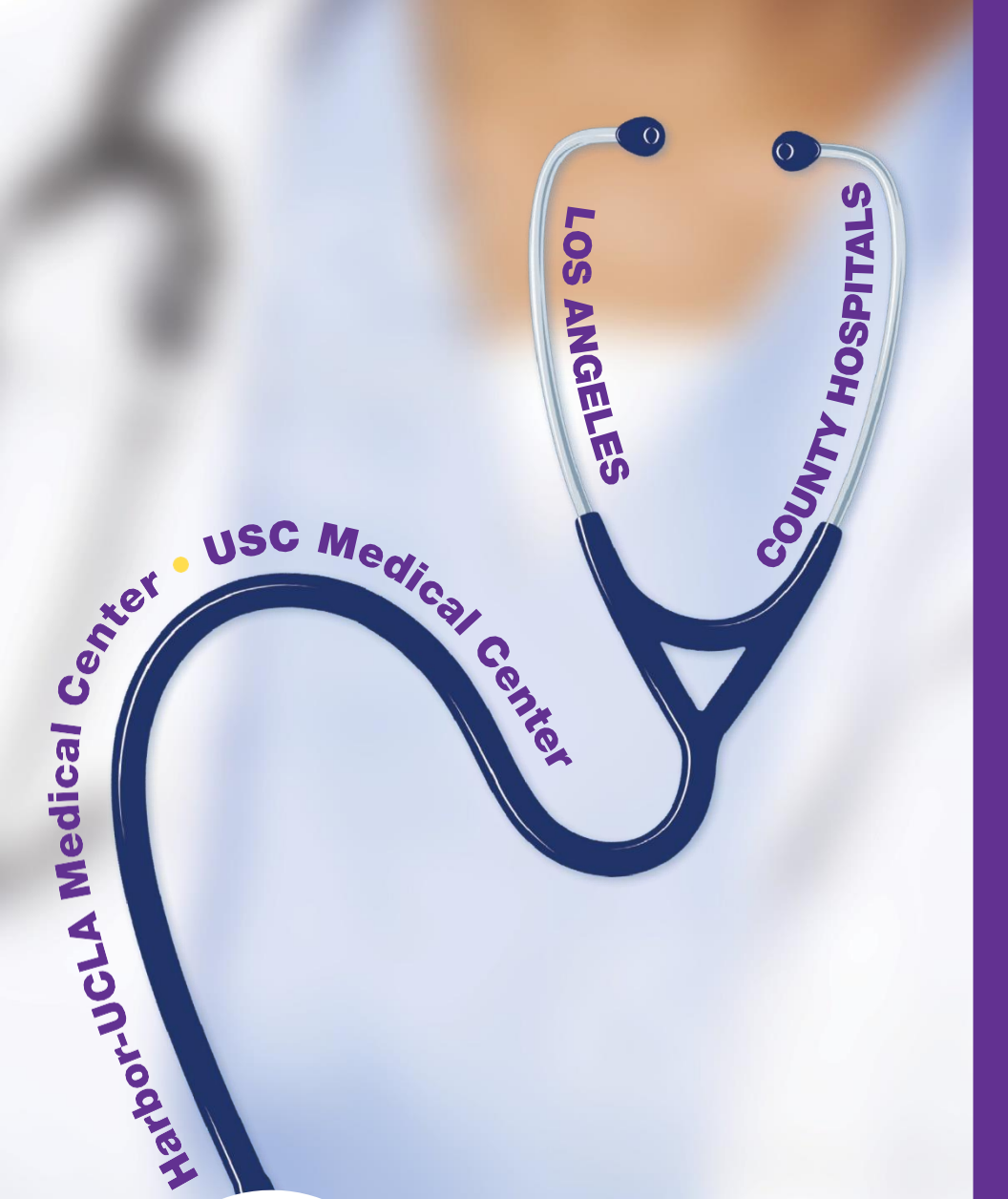

BENEFIT FUNDS

Committee of Interns and Residents

SEIUHealthcare®

SUMMARY PLAN DESCRIPTION

June 1, 2017

HOUSE STAFF BENEFITS PLAN

(HSBP)

LOS ANGELES COUNTY

HARBOR – UCLA MEDICAL CENTER
&
USC MEDICAL CENTER

SUMMARY PLAN DESCRIPTION
(SPD)
&
PLAN DOCUMENT

House Staff Benefits Plan of the Committee of Interns and Residents

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LOS ANGLES COUNTY
SOUTHERN CALIFORNIA
HOUSE STAFF BENEFITS PLAN

June 1, 2017

Dear Los Angeles County House Staff Officer:

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 a resident 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 + 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 Harbor – UCLA Medical Center and Los Angeles County USC Medical Center. 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 Los Angeles County residents are:

- LA Gap Insurance
- Vision Benefit
- Supplemental Short Term Disability
- Long Term Disability

This booklet also provides information on your other statutory benefits.

IMPORTANT NOTICE

This booklet describes your benefits which also serve 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 resident at:

1. Cambridge Health Alliance
2. CIR and HSBP employers
3. Highland General Hospital (Alameda County Medical Center)
4. Modesto/Valley Consortium for Medical Education
5. New York City Health + Hospitals
6. Santa Clara Valley 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.
- Residents 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 Off LA County Payroll

- If you rotate away from LA County 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 CIR 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.

Dependent(s) Eligibility Rule

Your eligible dependents include:

- Your spouse
- Your dependent children up to age 29
- Your registered domestic partner opposite or same sex (see Domestic Partner title for specific details)
- Coverage for your eligible dependents begins on the same day your coverage begins as long as you add your dependents on the same Enrollment Form you give to your CIR Organizer.

For the purposes of this Plan, a dependent child is any of your children (whether married or unmarried), up to their 29th birthday (end of calendar year), including:

- Your biological child;
- Your legally adopted child or a child placed for adoption (placed for adoption assumes retention by the Participant of a legal obligation for total or partial support of such child in anticipation of adoption);

- A step-child or foster-child;
- Your domestic partner's child
- An unmarried individual whom the resident has legal guardianship under a court order and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the Internal Revenue Code Section 152(c) or 152(d) OR who will be claimed as a dependent on the employee's tax return each plan year for which coverage is provided;
- A child named as an "alternate recipient" under a Qualified Medical Child Support Order.

A spouse or child of a Dependent Child is NOT eligible for coverage under the Plan.

Types of Proofs For Your Dependents

- You must provide sufficient proof of eligibility for your dependents:
    - Marriage Certificate
    - Domestic Partner Certificate
    - Birth Certificate for child(ren)

Enrolling Eligible Dependent(s)

Enrolling A Spouse

1. To enroll your spouse, you add them to the same Enrollment Form you are completing for yourself.
2. Provide a copy of your marriage certificate or first page of the IRS Form 1040.

Enrolling Dependent Child(ren)

To enroll your dependent child(ren), you must add them to the same Enrollment Form you are completing for yourself.

1. Attach a copy of their birth certificate or adoption/guardianship papers for child(ren) whom you have adopted or are legal guardian.

2. For step-child(ren), you also need to provide a copy of your marriage certificate between you and the children's parent.

We will not provide benefits to your eligible dependents without a completed Enrollment Form and the required documents.

Enrolling Domestic Partner

- To enroll your domestic partner, complete an Eligibility Update Form **and** a Domestic Partnership Application furnished by HSBP.
- You must provide proof that you are registered as domestic partners or documentation of shared financial responsibility.
- The domestic partnership application must be signed by both partners and notarized.

If you do not enroll your dependent(s) during your initial enrollment period in the HSBP Plan, you will be able to enroll them during one of the two open enrollment periods (January 1 or July 1)

Updating Contact Information

If you change your:

- Name
- Address
- Email
- Cell Phone

Complete the electronic Member Update Form found on CIR website under your hospital. The form will automatically be sent to the Benefit Office for processing.

Benefits Office

Phone: (212) 356-8180
Hours: Monday – Friday, 9:00 am – 5:00 EST
Email: benefits@cirseiu.org

LA GAP INSURANCE

(Self-Insured by the HSBP)

House Staff officers who are employed by the County of Los Angeles who experience a 2-month waiting period for LA County health insurance are eligible for this benefit.

This benefit reimburses up to a maximum of $500 for the purchase of COBRA or a form of GAP coverage to cover yourself and/or your family during this 60-day waiting period.

How to Submit For Reimbursement

To submit for reimbursement, you must complete:

- Complete the LA GAP Form
- If you elected COBRA from your prior coverage submit:
    a. A copy of the COBRA notice
    b. Proof of payment (e.g. canceled check, electronic payment.
    c. A copy of the receipt for purchasing the policy.
- Purchased GAP Insurance submit:
    a. A copy of the GAP policy statement
    b. Proof of payment (e.g. canceled check, electronic payment.
    c. A copy of the receipt for purchasing the policy.

One Year Submission Deadline

- All claims must be submitted to the House Staff Benefits Plan Office within one year from the end of the 2-month waiting period that was covered.
- Claims submitted after one year will be denied.

VISION BENEFIT

(This benefit is provided by Davis Vision)

Eligibility

You and your eligible dependent(s) are entitled to HSBP's Vision Benefits

- Your employer makes a contribution to the Plan on behalf of every House Staff Officer on its payroll.
- Therefore, this coverage is provided at no cost to you.

In-Network Benefits

The Plan offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependent(s) use your in-network benefits you will be entitled to:

- Free eye exam every July 1
- Lenses every July 1 (See copay chart for lens options and copay amounts)
- Frames once every two plan years (every *other* July 1) as follows:
  - Any Fashion frame from the Davis Vision Collection (valued up to $125) will be covered in full
  - A $15 copayment will be applied for a Designer frame
  - A $40 copayment will be applied for a Premier frame
- Contacts every July 1 (in lieu of eyeglasses)

Note: If you choose a frame that is NOT in the Davis Vision Collection, you will be given a $50 allowance towards any frame from the participating provider plus 20% off the balance.

Contacts Instead Of Glasses

- If you require a contact lens fitting, you will receive a 15% discount off the fitting exam when you visit an in-network provider.
- You will receive $100 allowance toward any provider supplied contact lenses, plus 15% off the balance.

How to Locate In-Network Providers

- Log on to the Open Enrollment section at www.davisvision.com.
- To use your in-network benefits, present your Davis Vision Member ID card or give the provider your first and last name.

Lens Types and Coatings	Copay
Clear Plastic Lenses, all ranges of prescriptions and sizes (single vision, bifocal, trifocal)	$0
Oversized Lenses	$0
Scratch Resistant Coating	$0
Tinting of Plastic Lenses	$15
Polycarbonate Lenses*	$15
Ultraviolet Coating	$15
Intermediate Vision Lenses	$30
Standard Progressives	$65
Premium Progressives (Vanilux®, etc.)	$105
Plastic Photosensitive Lenses (Transitions®)	$70
Polarized Lenses	$75
Standard Anti-Reflective (AR) Coating	$40
Premium AR Coating	$55
Ultra AR Coating	$69
High-Index Lenses	$60
Scratch Protection Plan (Single Vision | Multifocal)	$20 | $40

*Polycarbonate lenses covered in full for dependent children, monocular patients & patients with prescriptions 6.00 diopters or greater

Out-Of-Network Benefits

- You may receive services from an out-of-network provider; however, you will receive the greatest value when you go in-network.

- If you choose an out-of-network provider, you will receive a maximum of $40 per year toward an eye exam and $60 toward materials.

- You must file a claim with Davis Vision to be reimbursed.

Claims should be mailed to:

Vision Processing Unit
PO Box 1525
Latham, NY 11210

Other Discounts with Davis Vision

Davis Vision also provides discounts on laser vision correction and replacement contacts through LENS123©, a mail-order contact lens service. Visit davisvision.com for more information or contact Davis Vision at 1-877-923-2847.

APPEALS FOR VISION BENEFITS

Appeals for vision benefits should be directed to Davis Vision. Your request for review must be made in writing within 180 days after you receive notice of denial. Call Davis Vision Quality Assurance at 1-888-343-3470 or address your complaint, grievance or appeal to:

Davis Vision Inc.
Attention: Quality Assurance/Patient Advocate Dept.
PO Box 791
Latham, NY 12210

- If you are dissatisfied with the outcome of your appeal, you can file a Level 2 Appeal to the Trustees.
- Refer to the Claims and Appeals section of this booklet for more information.

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 resident only. If you become disabled while eligible for benefits under the Plan

- Supplemental Short-Term Disability Benefits begin on the (8^{th}) eighth 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.

The resident's spouse and other dependents are not eligible for this benefit.

What Is the Maximum Amount Of Disability Pay?

- The maximum benefit payable is 70% of your weekly salary up to a maximum of $875 per week.

- Your payment may come from different sources depending on the state in which you are employed as discussed later in this section and can include a statutory benefit as well as this Supplemental Short-Term Disability Benefit.

- This Supplemental Short-Term Disability Benefit payable by the Plan is the benefit amount above any statutory benefit provided by the state in which you are employed (if applicable) up to the maximum of $875 per week.

For Example:

- A resident submits documentation to the employer that they are going out on disability for 2 months.
- HSBP Supplemental Short-term Disability will pay up to $875 a week.
- California Insurance may pay from $50 to a maximum of $1,173 a week. *

***Go to California's government website for assistance at www.edd.ca.gov/Disability/SDI_Online.htm**

How Long Can I Receive Disability Pay?

Benefits are paid for a maximum of 26 weeks of disability during 52 consecutive weeks.

Payment of Weekly Benefits ends on the earlier of:

1. The date on which you are no longer disabled; or
2. After 26 weeks of disability benefits have been paid

If your Disability extends beyond twenty-six weeks, you may be eligible for Long Term Disability.

Partial Disability

- Partial Disability, as defined by the Plan as any period during which you are able to perform any work for remuneration, **is not covered under this plan**.

- Benefits will only be paid for periods during which you meet the definition "disability."

Reduction of Benefits

If you receive other income while receiving Short-Term Disability Benefits, the Short-Term Disability Benefits you would otherwise receive will be reduced by any such other income. Such other income may be:

- California state-mandated disability benefits;
- No-Fault wage replacement;
- Other statutory benefits; or
- Any amounts you receive for paid time off from your employer.

Exclusions

No benefits will be paid with respect to:

- Disabilities for work-related illnesses or accidents covered by Workers' Compensation or any other similar state or federal law;
- Any period during which you perform any work for remuneration or profit; or
- Any claim that is not filed within 60 days of the start of the first date of the disability, unless circumstances prevent you from filing the claim in a timely manner, in which case the claim must be filed within 12 weeks from the onset of disability.

LONG TERM DISABILITY (LTD)
Group # 348692

(This Benefit is insured through Guardian)

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

70% of your prior monthly earnings, rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $3,500.00.

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 - Filling 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.

Deadline to Convert to 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 provide Basic 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.

NOTICE OF ELECTRONIC DISCLOSURE

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 encryption, and Adobe Acrobat Reader. Adobe Acrobat Reader is available for download free of charge at http://get.adobe.com/reader/.

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

An 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 <u>other than</u> 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

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.

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.

- Obtain copies of Plan document upon written request to the Plan Manager.

- Receive a summary of the Plan's annual financial report.

- The Trustees who operate your Plan, called "fiduciaries," recognize that they have a duty to do so prudently and in the interest of you and other Plan employees and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under the Plan. If your claim for a benefit is denied, in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim and you have a right to appeal the decision to the Board of Trustees.

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 yearend 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.

HOUSE STAFF BENEFITS PLAN (HSBP)

Los Angeles County
Harbor—UCLA Medical Center
USC Medical Center

Summary Plan Description (SPD)
Plan Document
Effective June 1, 2017