House Staff Benefits Plan

of the Committee of Interns and Residents/SEIU

for NYC Health + Hospitals Bellevue, South Brooklyn, Harlem, Jacobi, Kings County, Lincoln, Metropolitan, and Woodhull

January 2024 Summary Plan Description/Plan Documents

HSBP of the Committee of Interns and Residents
10-27 46th Avenue, Suite 300-2
Long Island City, New York 11101
(212) 356-8180

Chairperson, Board of Trustees
Lorenzo Gonzalez, MD, MPL

Board of Trustees
Yariana Rodriguez Ortiz, MD
Michael Zingman, MD, MPH
Fan Jim Yang, MD

Interim Fund Administrator
Sheila Blanc

Legal Counsel
Cohen, Weiss & Simon LLP

Auditor
Rogoff & Company, PC

Consultant
Segal

TABLE OF CONTENTS

IMPORTANT NOTICES 1
HOUSE STAFF BENEFITS PLAN 2
of the committee of interns and residents/seiu 2
house staff benefits plan 3
of the committee of interns and residents/seiu 3
GENERAL BENEFITS SUMMARY 3
HSBP BENEFITS ELIGIBILITY AND ENROLLMENT 5
Initial Eligibility for HSBP 5
Plan Year 5
Dependent Eligibility 5
How to Enroll Yourself and Your Dependents 7
Late Enrollment 7
Enrolling Eligible Dependents 7
Enrolling Domestic Partners 8
Open Enrollment 8
Change in Family Status 9
Special Enrollment 10
TERMINATION AND EXTENSION OF COVERAGE 11
Rescission of Coverage 11
Extension and Continuation of Coverage 12
Qualified Medical Child Support Orders (QMCSO) 12
Enrollment Related to a Valid QMCSO 12
Family and Medical Leave 13
Continued Coverage in Cases of Military Leave (USERRA) 13
Reinstatement of Coverage after Leaves of Absence 14
Child Care Benefit 16
Eligibility 16
Types of Eligible Caregivers 16
Exclusions 17
How to Make a Claim 17
Assistance In Finding Child Care Services 17
CONTINUING LEARNING PROGRAM (CLP) 19
(INSURED BY HSBP) 19
Eligible for Reimbursement if Work-Related and Medical in Nature 19
Rotations Between Employers 20
How to Make a Claim 20
Dental Benefits (Insured by Guardian Dental Insurance – Group #417732) 22
managed dentalguard (mdg) 24
Choice of Dentists 24
Specialty Referrals 24
Emergency Dental Services 25
Out-Of-Area Emergency Dental Services 25
Covered Dental Services and Patient Charges 25
Alternative Procedures 25
DentalGuard Preferred (DGP) 26

COVERED CHARGES 26
MAXIMUM ROLLOVER PROVISIONS APPLYING ONLY TO DENTALGUARD PREFERRED MEMBERS 27
Guardian Customer Service 28
HEARING AID BENEFIT 32
(INSURED BY hsbp) 32
How to Make a Claim 32
IDENTITY THEFT MONITORING AND PROTECTION BENEFIT 33
(INSURED BY IDENTITYFORCE) 33
VISION BENEFIT 35
(INSURED BY HSBP) 35
Other Vision Benefits 35
Appealing Vision Coverage 39
QUALITY IMPROVEMENT (QI)/PATIENT SAFETY EDUCATION AND TRAINING SCHOLARSHIP 40
SUPPLEMENTAL REIMBURSEMENTS 44
SUPPLEMENTAL DENTAL BENEFIT - $1,000 (per person) (insured BY HSBP) 45
SUPPLEMENTAL MAJOR MEDICAL BENEFIT - $1,000 (per person) (insured BY HSBP) 48
Smoking Cessation Benefit 48
SUPPLEMENTAL OUTPATIENT MENTAL HEALTH BENEFIT - $5,000 (per person) (insured BY HSBP) 50
SUBSTANCE USE DISORDER COUNSELING AND TREATMENT BENEFIT (insured by HSBP) 50
SUPPLEMENTAL NEWBORN BENEFITS - $1,000(insured by HSBP) 53
SUPPLEMENTAL OBSTETRICAL BENEFIT - $1,000 (per child) (insured by HSBP) 55
SUPPLEMENTAL prescription drug BENEFIT - $750 (per person) (insured by HSBP) 57
Prescription ID Cards 57
For replacement of a lost card, you may also contact Express Scripts at (800) 467-2006. 57
Who Is Eligible To Use the Prescription ID Card? 57
Do I Throw The ID Card Away After I Exhaust the $750? 57
What Are Considered Eligible Prescriptions? 58
For participants enrolled in the NYC PICA Program, you may use this benefit to cover copayments for certain non-specialty injectables that are covered by Express Scripts. Please contact Express Scripts at the customer service phone number on the back of your prescription ID card for more information about covered injectables. 58
How Do I Find the Balance on My Card? 58
For additional savings on long-term medications, you can use ESI's mail order, home delivery program to get a ninety (90) day supply for the cost of two (2) copayments. Orders and refills are available through the Express Scripts app, by phone, by mail, or your provider can submit the request electronically. You must have a prescription from your provider. For more information about your plan or to transfer a retail prescription to home delivery, visit express-scripts.com or call Express Scripts at (800) 467-2006. 58
What If I Forgot To Use My Prescription Card and Paid, Used a Non-Participating Pharmacy, or Paid Copayments Under My Primary Prescription Plan? 58
Benefits to Assist in Gender Affirming Care 60
Supplemental Short-Term Disability 62
(Self-Insured by HSBP) 62
Definition of Disability 62

Reduction of Benefits 62
Exclusions 63

DISABILITY – LONG TERM Group # 348692 64

(INSURED BY GUARDIAN) 64

Application for Other Income Required 64
Computing Your Net Monthly Benefit and Net Monthly Payment from This Plan 64
Waiver of Premium 65
Rehabilitation Benefits under This Plan 65
Special Limitations: Mental or Emotional Conditions, and Substance Use Disorder 65
Converting Your Group Long Term Disability Income Insurance 66
The Converted Individual Disability Income Policy 66
Filing a Claim for Long-Term Disability Benefits 67

INSMED Disability BENEFITS fOR EMployees 69

CONTINUATION OF HSBP BENEFITS WHILE YOU ARE DISABLED 70

(INSURED BY HSBP) 70

GROUP TERM LIFE INSURANCE 71
Group Term Life Insurance During Total Disability 71
Accelerated Life Benefit 72

LIFE TERM INSURANCE FOR YOUR SPOUSE OR DOMESTIC PARTNER 74

(insured by guardian life insurance) 74

ANCILLARY DEATH BENEFIT 75

(insured by hsbp) 75

ACCIDENTAL DISMEMBERMENT BENEFIT 76

(insured by hsbp) 76

CLAIMS INFORMATION 77

How to make a claim for HSBP Benefits 77
Time to File Claims 77

CLAIMS REVIEW AND APPEAL PROCEDURE 78

COORDINATION OF BENEFITS 82

(**Guardian Dental Benefits Only)** 82

NOTICE OF ELECTRONIC DISCLOSURE 87

HOUSE STAFF BENEFITS PLAN ADDITIONAL PLAN INFORMATION 88

COBRA GENERAL (INITIAL) NOTICE 90

Alternatives to COBRA Continuation Coverage 92

HIPAA PRIVACY PRACTICES 101

OF THE HOUSE STAFF BENEFITS PLAN 101

STATEMENT OF PARTICIPANT RIGHTS 104

HOUSE STAFF BENEFITS PLAN

IMPORTANT NOTICES

This document describes your benefits. Do not rely on statements made by any individual(s). The only authorized information concerning your benefits must be in writing from the Board of Trustees, who are acting within their official capacity. The Board of Trustees has not empowered anyone else to speak for them with regard to the House Staff Benefits Plan (HSBP). No employer representative or supervisor is in a position to discuss your rights under HSBP with authority. If you have any questions about any aspect of your participation in HSBP, you should for your own permanent record, write to the Benefits Office or the Board of Trustees. You will then receive a written response, which will provide you with a permanent reference.

The Trustees reserve the right, in their sole discretion, to change or discontinue the types and amounts of benefits under HSBP and to interpret, construe, and apply the terms of HSBP or the eligibility rules, including those rules providing extended or accumulated eligibility, even if the eligibility has already been accumulated. Written amendments are periodically made to HSBP and distributed to employees and dependents. Please retain any amendments to this document for easy reference.

GENERAL PLAN INFORMATION

This booklet describes all the benefits provided to you through the House Staff Benefits Plan (HSBP): Child Care, Continuing Learning Program, Dental, Disability (Short-Term and Long-Term), Hearing Aid, ID Theft Monitoring, Term Life Insurance for you and your Spouse or Domestic Partner, Quality Improvement Scholarship, Supplemental Benefits (Dental, Major Medical, Mental Health Outpatient, Newborn Benefits, Obstetrical and Prescription Drug), Substance Use Disorder Counseling and Treatment, Vision Benefits and Accidental Dismemberment.

This booklet also provides information on HIPAA, COBRA, and other laws that impact your benefits.

NOTICE OF GRANDFATHERED HEALTH PLAN

HSBP believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, following the appeals process.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at the Benefits Office at 212-356-8180. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

HOUSE STAFF BENEFITS PLAN
OF THE COMMITTEE OF INTERNS AND RESIDENTS/SEIU

January 2024

Dear House Staff Officers, residents, fellows, and Dependents,

We are pleased to present you with this revised and updated Summary Plan Description (SPD), which also serves as the Plan Documents for the House Staff Benefits Plan (HSBP). This booklet describes the benefits available to you through HSBP and PEP of the Committee of Interns and Residents (CIR).

HSBP is a benefit trust fund, financed by contributions fixed by Collective Bargaining agreements or other written agreements, and administered by a Board of Trustees designated by CIR pursuant to the HSBP Agreement and Declaration of Trust (HSBP Trust Agreement), which may be amended from time to time. The HSBP Trust Agreement gives the Board of Trustees authority and discretion to determine benefits, and the Trustees have accordingly adopted the plans of benefits described in this SPD for employees (House Staff Officers, residents, and fellows), employed by New York City Health and Hospitals. Under the HSBP Trust Agreement and this SPD, the Trustees may, at their discretion, revise, discontinue, improve, reduce, modify or make changes in the plans, the types and amounts of benefits provided, the coverage and eligibility provisions, conditions and rules, at any time. Any question of interpretation, construction, application, or enforcement of the terms of the plan and this SPD, 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.

HSBP receives its funds pursuant to the terms of the Collective Bargaining Agreement(s) negotiated by CIR on your behalf. The collective bargaining agreements requires your participating employer to make contributions to HSBP at a fixed rate per employee.

The SPD describes the benefits to which you and your family are entitled, eligibility guidelines, rules and regulations and the procedures to follow to obtain benefits and information. We urge you to read this document carefully, as there have been changes and improvements in your benefits, and keep it handy for future reference.

The Trustees believe that your benefits plans will be a valuable asset to you and your family. If you have any questions regarding this material, please call, email or write the Benefits Office.

Sincerely,
The Board of Trustees

HOUSE STAFF BENEFITS PLAN
OF THE COMMITTEE OF INTERNS AND RESIDENTS/SEIU

GENERAL BENEFITS SUMMARY

PLAN YEAR: JULY 1 – JUNE 30

Benefit	Insurer	Contact	Other Important Documents Incorporated Into This SPD
Child Care*	HSBP	HSBP Benefits Office 10-27 46th Avenue, Suite 300-2 Long Island City, New York 11101 (212) 356-8180 benefits@cirbenefitfunds.org	N/A
Continuing Learning Program	HSBP		N/A
Short-Term Disability	HSBP		N/A
Long-Term Disability (including the Employee Assistance Program)	Guardian	Guardian Group #348692 (800) 525-4542	Guardian Basic Life and Long Term Disability Certificate of Coverage Class #0001
Supplemental Benefits Supplemental Dental Supplemental Major Medical Supplemental Outpatient Mental Health Supplemental Newborn Supplemental Obstetrical Supplemental Prescription Drugs Substance Use Disorder Counseling & Treatment Benefit	HSBP	HSBP Benefits Office 10-27 46th Avenue, Suite 300-2 Long Island City, New York 11101 (212) 356-8180 benefits@cirbenefitfunds.org	N/A
Quality Improvement/Patient Safety Education and Training Scholarships	HSBP		N/A
Prescription Drugs	HSBP (Administered by ESI)	Express Scripts Inc. (ESI) Group #JRG (866) 439-3658 www.express-scripts.com	N/A
Dental Coverage Managed DentalGuard (MDG) DentalGuard Preferred (DGP)	Guardian	Guardian Dental Group #G417732 www.guardianlife.com (888) 600-1600	Guardian Dental Certificate of Coverage Class #0001
Hearing Aid	HSBP	EPIC Hearing (866) 956-5400 www.epichearing.com	N/A
Identity Theft Monitoring	IdentityForce	IdentityForce (877) 694-3367	N/A
Life Insurance	Guardian	Guardian Group #348692 (800) 525-4542	Guardian Basic Life and Long Term Disability Certificate of Coverage Class #0001
Accidental Dismemberment	HSBP	HSBP Benefits Office 10-27 46th Avenue, Suite 300-2 Long Island City, New York 11101 (212) 356-8180	N/A

Benefit	Insurer	Contact	Other Important Documents Incorporated Into This SPD
		benefits@cirbenefitfunds.org	
Vision Benefits	HSBP	Davis Vision Client Code 2200 (877) 923-2847	HSBP Davis Vision Flyer

**Please note: this benefit is not administered on a Plan Year basis; see appropriate section below for more information.*

HSBP BENEFITS ELIGIBILITY AND ENROLLMENT

Initial Eligibility for HSBP

This SPD covers employees of New York City Health + Hospitals (NYC H + H) who are covered by the collective bargaining agreement between the Committee of Interns and Residents (CIR) and NYC H.+ H. If you are an employee of NYC H + H and covered by the above-mentioned collective bargaining agreement, then you are eligible to participate in HSBP from the date of your hire when you go on your participating employer's payroll. To become eligible for benefits an employee must work a minimum of 20 hours per week and contributions must be received on the employee's behalf.

You are also eligible for basic health insurance, which is provided by the hospital at which you are employed, under the contract between CIR and your participating employer. The basic health insurance plan with your participating employer is considered your primary insurance and insures not only you, but also your eligible dependents (i.e., your spouse, your domestic partner, and eligible dependent children). Enrollment for this basic plan is your responsibility and is required before you receive the supplemental benefits described in this SPD; you should check with your participating employer's human resources or personnel office at the beginning of each contract year to verify that your primary insurance is still in effect.

The benefits offered by HSBP are not intended to act as or replace the primary insurance provided by your participating employer. The benefits offered by HSBP are supplemental to your primary insurance.

Plan Year

The HSBP Plan Year is from July 1st to June 30th.

Off-Cycle Hires (applicable for all benefits with annual limits except dental and prescription drug coverage)

Please note, employees who are hired outside the start of the Plan Year (usually July 1) will be eligible for benefits as of the date they go on their participating employer's payroll but their initial Benefit Cycle will run from their date of hire through June 30th of the following year (or until the date of termination, whichever is earlier). **If you are hired prior to the month of July your first Benefit Cycle will be longer than twelve (12) months; however you are not entitled to any additional benefits beyond what is offered during the subsequent twelve (12) month Plan Year**. Your second Benefit Cycle will begin the following July 1 and last until the following June 30th and will correspond with the Plan Year.

For Example:

- If you are hired on June 25, 2023, your Benefit Cycle will be June 25, 2023 through June 30, 2024. You will be eligible for benefits as of June 25, 2023. The maximum benefits that you are eligible for during this initial Benefit Cycle will be the maximum benefits that are available for the Plan Year that begins on July 1, 2023 and ends on June 30, 2024.
- The following year, your Benefit Cycle will be July 1, 2024 through June 30, 2025, and will correspond with the Plan Year.

All other eligibility and termination rules will remain the same.

Rotation Away From NYC Health + Hospitals

If, during a rotation away from your hospital, you switch from your current hospital's payroll to the payroll of a hospital that is not a participating employer of 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-participating employer payroll.

Dependent Eligibility

Coverage of your eligible dependents begins on the same day your coverage begins as long as you enroll them when you complete your Enrollment Form and provide sufficient proof of eligibility.

Not all of your dependents receive the same benefits:

Your spouse or domestic partner is eligible for Spouse/Domestic Partner Life Insurance.

Your spouse or domestic partner and dependent children up to age 29 are eligible for Dental, Hearing Aid, Vision and Supplemental benefits.

BENEFIT ELIGIBILITY CHART (an "X" indicates eligibility for the benefit)			
Benefit	**Employee**	**Dependent Children**	**Spouse/Domestic Partner**
Accidental Dismemberment	X		
Child Care Benefit (this benefit is per household)	X		
Continuing Learning Program	X		
Hearing Aid Benefit	X	X	X
Identity Theft Protection Program	X		
Life Insurance	X		X
Quality Improvement/Patient Safety Education and Training Scholarship	X		
Short-Term and Long-Term Disability	X		
Supplemental Dental Benefit	X	X	X
Supplemental Major Medical Benefit and Smoking Cessation Benefit	X	X	X
Supplemental Outpatient Mental Health Benefit	X	X	X
Supplemental Newborn Benefit		X	
Supplemental Obstetrical Benefit	X	X	X

Your eligible dependents include:

- Your spouse to whom you are legally married and from whom you are not legally separated;
- Your domestic partner, opposite or same sex (see below for specific details);
- A dependent child (whether married or unmarried), up to the end of the calendar year of their 29th birthday, including:
    - Your biological child;
    - Your legally adopted child or a child placed for adoption ("placed for adoption" assumes retention by the employee of a legal obligation for total or partial support of such child in anticipation of adoption);
    - A stepchild or foster child;
    - Your domestic partner's child;
    - An unmarried individual whom the employee 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.
- Unmarried Disabled Children over age 29

- Coverage for dependent children will not terminate for unmarried disabled children who, regardless of age, are incapable of self-sustaining employment by reason of mental disability, developmental disability, or physical disability, and who became disabled prior to reaching the age limit of the HSBP.
- Such coverage shall not terminate while the resident's coverage remains in effect, and the dependent remains disabled and is chiefly dependent on the resident for support and maintenance.
- The resident must submit proof of such dependent's incapacity within 31 days of dependent's attainment of age limit.

A spouse or child of a dependent child is not eligible for coverage under HSBP.

How to Enroll Yourself and Your Dependents

You **must** complete an **Enrollment Form** in order for you and your eligible dependents to be eligible for benefits and submit it within thirty-one (31) days of your hire date. The enrollment form must be submitted to the Benefits Office. Enrollment Forms are provided during orientation and can be found on the CIR website at https://www.cirseiu.org/benefits or the Member Portal at https://cirmp.novus-360.com/cirmpprod.

If you do not complete and return an Enrollment Form, you (and your dependent(s), if applicable) will not be eligible for benefits and claims will be denied under HSBP.

Late Enrollment

If your enrollment for you or your dependents, if applicable, is received after 31 days from the date of your hire, you will be enrolled during HSBP's next open enrollment period unless you qualify for Special Enrollment. See the *Open Enrollment* and *Special Enrollment* sections for more information.

Enrolling Eligible Dependents

If you have eligible dependents you wish to enroll, you must provide necessary proof of dependent status as listed below along with the Enrollment Form. If the Benefits Office does not receive a completed Enrollment Form and the documentation listed below, the Benefits Office will not enroll and provide benefits to your dependents and claims will be denied under HSBP.

- Spouse: To enroll your spouse, you must provide a copy of your official, state-issued marriage certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized.
- Biological Child: To enroll your biological child(ren), you must provide a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized.
- Stepchild: To enroll stepchild(ren), you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized, and 2) a copy of the official, state-issued marriage certificate between you and your spouse as the child(ren)'s parent (or the Plan's form affidavit, which has been notarized).
- Adopted Child or Placement for Adoption: To enroll adopted child(ren) or child(ren) placed for adoption, you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized, and 2) a copy of the certified court order signed by a judge.
- Child covered pursuant to a Qualified Medical Child Support Order (QMCSO): To enroll child(ren) covered pursuant to a QMSCO, you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, available upon request, which has been notarized, and 2) a copy of the certified QMCSO document signed by a judge or a National Medical Support Notice.
- Legal Guardianship: To enroll child(ren) for whom you are a legal guardian, you must provide 1) a copy of their official, state-issued birth certificate or if unavailable, the Plan's form affidavit, which has been notarized, and 2) a copy of the court-appointed legal guardianship documents.
- Unmarried Disabled Dependent Child: As discussed above, coverage will not terminate for unmarried disabled children who, regardless of age, are incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical disability, and who became disabled prior to

reaching age 29, so long as the resident's coverage remains in effect and the dependent remains disabled and chiefly dependent on the resident for support and maintenance. If you have not provided the information below upon enrolling your disabled dependent child, you **must** submit proof of the dependent's incapacity within 31 days of the disabled dependent child's attainment of age 29 to maintain enrollment of the disabled dependent child. You must provide:

(1) a current written statement from the child's physician indicating the physician's assessment that the child is currently mentally or physically disabled;

(2) a notarized statement that the child is incapable of self-sustaining employment as a result of that disability; and

(3) a notarized statement and proof that the child is dependent chiefly on you and/or your spouse for support and maintenance.

Enrolling Domestic Partners

- To enroll your domestic partner and/or the child(ren) of your domestic partner, you must complete a Domestic Partnership Application. The Domestic Partnership Application must be signed by both partners and notarized. The Domestic Partnership Application can be on the website under the Benefits tab and by your hospital's name. If you have a domestic partnership, you must provide proof that you are registered as domestic partners. If your domestic partnership certificate cannot be located, you may also complete the Plan's form affidavit, which has to be notarized. The Plan's form affidavit can be found on the website under the Benefits tab and by your hospital's name.
- If you are not providing proof of a domestic partnership, you must prove domestic partnership status by providing documentation to show two (2) of the following:
    - Common ownership of real property or a common leasehold interest in such property
    - Common ownership of a motor vehicle
    - Joint bank accounts or credit accounts
    - Evidence of common household expenses such as a utility or telephone
    - Evidence of joint obligation on a loan
    - Designation as a beneficiary for life insurance or retirement benefits or under the partner's will
    - Assignment of a durable power of attorney or health care power of attorney

By law you are responsible for paying taxes on the value of your domestic partner benefit called Imputed Income. In some situations, may also be responsible for paying taxes on the value of benefits provided to the child(ren) of your domestic partner. You will be notified of the amount by your participating employer. Please note domestic partners of employees employed at an NYC Health + Hospitals do not have to be enrolled with the City of New York insurance benefits to be eligible for supplemental HSBP benefits. However, you must complete a Domestic Partnership Application. This information is kept strictly confidential.

Domestic Partners will generally not qualify as tax dependents of the employee and as such, the employee will be taxed on the value of the benefit provided to the Domestic Partner. This is called "imputed income" and the employee will have to pay tax on this amount. Please consult with an appropriate tax accountant if you choose to enroll a domestic partner or the child(ren) of your domestic partner.

Open Enrollment

HSBP has two open enrollment periods each year:

1. June 1st through July 31st, with an effective date of July 1st; and
2. December 1st through January 31st, with an effective date of January 1st.

If you do not enroll yourself and/or your eligible dependents when you are first eligible for coverage within thirty-one (31) days of your hire date, you may enroll yourself and your eligible dependents during either of

the open enrollment periods December 1st through December 31st (to be effective January 1st) or June 1st through July 31st (to be effective July 1st of each year). During open enrollment, you will also be able to switch between dental options. Please see the *Special Enrollment* section for additional ways you may enroll yourself or your eligible dependents outside of your initial eligibility or open enrollment.

If you initially enrolled yourself and/or your dependent(s) and later wish to dis-enroll yourself and/or any or all of your dependent(s)you and your dependent(s) will be required to complete an electronic Disenrollment Form.

- If, at a later date, you want the coverage you declined for yourself and/or your dependents, you may enroll only under the Special Enrollment provisions described below or during the open enrollment periods December 1 – 31 and June 1 – July 31 of each year.
- Note that no additional compensation is paid to you if you or your eligible dependent(s) waive/decline benefit coverage.

Change in Family Status

HSBP does not provide primary prescription, basic hospital, basic or major medical insurance as defined by the New York State Insurance Department. These benefits are provided through the hospital where you are employed. You must also notify your participating employer with any change in family status. You must notify the Benefits Office within thirty-one (31) days (by completing an electronic Update Form) when you have a change in family status and/or want to change your life insurance beneficiary. A change in family status occurs in the event of:

- The death of an enrolled dependent child, spouse, or domestic partner.
- You divorce, legally separate, your marriage is annulled, or you terminate your domestic partnership relationship.
- Your dependent child reaches HSBP’s age limit described on page 6 of this SPD.

It is your responsibility to ensure that the Benefits Office has up to date information for you and your enrolled dependents. Please notify the Benefits Office upon the following:

- You or your eligible dependent has a name change.
- You or your eligible dependent has an address change.
- You move out of your dental plan’s coverage area.
- You receive or change your Social Security Number.
- Your dependent child becomes physically or mentally disabled.
- You or your eligible dependent becomes enrolled in, or loses coverage under another dental plan or vision plan.

All changes in status require copies of the appropriate documents to be attached to the Update Form before electronically submitting to the Benefits Office.

Failure to give HSBP timely notice of changes to your spouse, domestic partner, and/or dependent child(ren)’s eligibility status will cause your spouse, domestic partner, and/or dependent child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a dependent child to end when it otherwise might continue because of a physical or mental disability. If you fail to provide notice to HSBP and your ineligible spouse, domestic partner, and/or dependent child(ren) remain covered, you will be responsible for reimbursing HSBP for any claims or any premiums that are paid on behalf of your spouse, domestic partner, and/or dependent child(ren) who are no longer eligible for coverage under HSBP. The

Board of Trustees may commence legal action against an employee or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the employee or dependent to recover amounts owed.

Special Enrollment

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future enroll yourself and/or dependents in HSBP, if you request enrollment within thirty-one (31) days from the date their or your previous coverage ends (or the participating employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, immigration, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within thirty-one (31) days from the date of marriage, birth, adoption, or placement for adoption.

If you did not enroll yourself or your dependents in HSBP when first eligible, you may enroll yourself if you and your dependents have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and lose eligibility for that coverage. In addition, you may also enroll yourself and/or your dependents in HSBP if you and/or they become eligible for a premium assistance program through Medicaid or SCHIP. However, you must request enrollment within sixty (60) days after the loss of coverage through Medicaid or SCHIP or eligibility for a premium assistance program through Medicaid or SCHIP.

To request special enrollment, submit your information and documents within the applicable thirty-one (31) day or sixty (60) day deadline set forth above to the Benefits Office by going on the CIR website at https://www.cirseiu.org/benefits and submitting an Update Form.

Start of Coverage Following Special Enrollment

Provided you enroll within the necessary timeframes for special enrollment, coverage will be effective:

- If you add a new dependent due to the birth of that dependent, the dependent will be covered from the date of birth (provided you enroll a baby within thirty-one (31) days).
- Your newly adopted dependent child or child "placed for adoption" with you will be covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support for the child whom you plan to adopt. A child who is placed for adoption with you within thirty-one (31) days after the child is born will be covered from birth if you comply with HSBP's requirements for obtaining coverage for a newborn dependent child. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.
- Coverage for your new spouse begins on the day you marry, provided you properly enroll your spouse within thirty-one (31) days of your marriage. Until your spouse is enrolled in HSBP, no claims will be paid for him or her.
- Following loss of other group coverage: your dependent(s) will be covered retroactive to date of loss of other coverage, provided you enroll your dependent(s) within thirty-one (31) days of the loss of that other coverage.
- Following loss of coverage under or eligibility for Medicaid/SCHIP, provided you enroll within sixty (60) days of the loss of Medicaid/SCHIP coverage, your coverage change will become effective the date of your request.

TERMINATION AND EXTENSION OF COVERAGE

When Coverage Ends for All Benefits

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

- your employment ends; or
- you are no longer eligible to participate in HSBP, including, but not limited to, if you switch from your current hospital's payroll to the payroll of a hospital that is not a participating employer of HSBP; or
- you enter active military service lasting more than thirty-one (31) days.

Coverage of your covered dependent(s) ends on the last day of the month in which:

- your own coverage ends; or
- your covered spouse, domestic partner or dependent child(ren) no longer meet this Plan's definition of spouse, domestic partner, or dependent child(ren).

Failure to give HSBP timely notice of changes to your dependent child(ren)'s eligibility status will cause the coverage of a dependent child to end when it otherwise might continue because of a physical or mental disability. If you fail to provide timely notice to HSBP of changes to your spouse's or domestic partner's eligibility status and/or that of your dependent child(ren), and your ineligible spouse, domestic partner, and/or dependent child(ren) remain covered, you will be responsible for reimbursing HSBP for any claims or any premiums that are paid on behalf of your spouse, domestic partner, and/or dependent child(ren) who are no longer eligible for coverage under HSBP.

Coverage for you (the employee) and/or your Dependents may be terminated retroactively due to non-payment of premiums (including COBRA premiums). Failure to notify HSBP of a loss of dependent status for any dependents (including as a result of divorce or legal separation or a child aging out of HSBP or a child no longer meeting the definition of disabled child) coupled with a failure to pay COBRA premiums will cause coverage to be terminated retroactively to the date of the event.

If coverage is terminated, you may be required to repay to HSBP amounts incorrectly paid by HSBP. The Board of Trustees may commence legal action against an employee or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the employee or dependent to recover amounts owed.

Rescission of Coverage

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to HSBP with respect to that claim.

Coverage for you (the employee) and/or your dependents may be terminated retroactively (rescinded) in cases of fraud or intentional misrepresentation. In such cases, you will be provided with thirty (30) day advance notice that coverage will be rescinded.

Note that a retroactive termination of coverage due to non-payment of premiums (including COBRA premiums) is not considered a rescission. Similarly, a retroactive termination due to your failure to notify HSBP of a loss of eligibility for your spouse due to divorce will not constitute a rescission of coverage if COBRA premiums have also not been paid. In these situations, coverage will be terminated retroactively to the date of the event (without advance notice). If coverage is terminated, you may be required to repay to HSBP amounts incorrectly paid by HSBP. The Board of Trustees may commence legal action against an employee or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the employee or dependent to recover amounts owed.

Extension and Continuation of Coverage

HSBP does not provide benefits for any expenses incurred after coverage ends. However, there are times when your coverage can be continued. Refer to the sections on *COBRA Continuation Coverage*, *Family and Medical Leave*, *Extension and Continuation of Coverage under Disability*, and *USERRA* for more information.

Contact the Benefits Office for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

HSBP will provide benefits in accordance with a National Medical Support Notice. In this document, the term Qualified Medical Child Support Order (QMCSO) is used and includes compliance with a National Medical Support Notice. According to federal law, a QMCSO is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. A QMCSO usually results from a divorce or legal separation and typically:

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

An order is not a QMCSO if it requires HSBP to provide any type or form of benefit or any benefit option that HSBP does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. All QMSCOs should be directed to the Benefits Office, and the Benefits Office will notify the parents and each child if an order is determined to be a QMCSO and if the employee is covered by HSBP, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

For Information: For information (free of charge) regarding the procedures for administration of QMCSOs, contact the Benefits Office.

Enrollment Related to a Valid QMCSO

If HSBP determines a QMCSO is valid, it will accept enrollment of the alternate recipient as of the earliest date following the date HSBP determined the order was valid, without regard to typical enrollment restrictions.

- If the employee already participates in HSBP, the QMCSO may require HSBP to provide coverage for the employee's dependent child(ren) and to accept contributions for that coverage from a parent who does not participate in HSBP. HSBP will accept a QMCSO Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received.

- If the employee does not participate in HSBP when the QMCSO is received and the QMCSO orders the employee to provide coverage for the alternate recipient, HSBP will accept a Special Enrollment of the employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received.

- Coverage will be subject to all terms and provisions of HSBP, including any limits on selection of provider and requirements for authorization of services, as permitted by applicable law.

Generally, coverage under HSBP terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under HSBP for other dependent children. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. For COBRA eligibility and enrollment requirements, see the COBRA section of this document.

Family and Medical Leave

If you have worked at least 1,250 hours in the last twelve (12) months, completed twelve (12) months of employment and you work for an employer covered by the Family and Medical Leave Act (FMLA), you may be entitled by law to up to twelve (12) weeks each year of unpaid family and medical Leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. Your participating employer is responsible for determining and granting the leave and will notify the Benefits Office when you take a leave subject to FMLA.

HSBP will continue benefits for the employee and their dependents during the employee's leave on the same basis as prior to the beginning of the leave. You will be responsible for making any required employee contributions; no employee contributions are currently required. The participating employer must remit the required contributions to HSBP during your FMLA leave. While you are officially on such a FMLA leave, you can keep benefit coverages for yourself and your dependents in effect during that FMLA leave period by continuing to pay any required contributions.

You may also be eligible to take Paid Family Leave under the New York Paid Family Leave Law or other statutory leave laws.

If you are eligible for FMLA, New York Paid Family Leave, or other statutory leave, your participating employer is responsible for granting the Leave and will notify the Benefits Office when you take a leave. HSBP will continue benefits for the employee and their dependents during the employee's leave on the same basis as prior to the beginning of the leave. You will be responsible for making any required employee contributions; no employee contributions are currently required.

Any changes in HSBP's terms, rules or practices that went into effect while you were away on that leave will apply to you and your dependents in the same way they apply to all other employees and their dependents. Please note, family and medical leave is your participating employer's responsibility so you will only be eligible for benefits if HSBP continues to receive contributions from your participating employer.

To find out more about family and medical leave and the terms on which you may be entitled to it as well as paying applicable premiums while you are on leave, if any, contact your participating employer's human resources or personnel office. If you have any questions about how a leave of absence affects your benefits, please contact the Benefits Office.

Continued Coverage in Cases of Military Leave (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides for a temporary continuation of health coverage when it would otherwise end because you have been called to active military duty. USERRA protects employees who leave for, and return from, any type of uniformed service in the United States armed forces.

If you are on active military duty for thirty (30) days or less, you (and any eligible dependents covered under HSBP on the day your leave starts) will continue to receive health coverage in accordance with USERRA at no cost to you.

If you are on active military duty for thirty-one (31) or more days, USERRA permits you to continue your medical and dental coverage under HSBP for you and your dependents, at your own expense, for the lesser of (i) twenty-four (24) months, or (ii) the period of qualified military service (i.e., generally, the period beginning on the date that your qualified military absence begins and ending on the date on which you fail to apply for, or return to, a position with your participating employer).

Duty to Notify

HSBP will offer you continuation coverage only after it is notified by you or your participating employer that you have been called to active duty in the uniformed services. In order to be eligible for this continued coverage, you must notify your participating employer, as far in advance as is reasonable under the circumstances, that you are leaving for military service, unless circumstances or military necessity make notification impossible or unreasonable.

Electing Continuation Coverage

Once HSBP receives notice that you have been called to active duty, HSBP will offer you (and any eligible dependents covered under HSBP on the day the leave started) the right to elect to continue coverage. HSBP's rules regarding the procedures for electing and paying for COBRA coverage apply to USERRA continuation coverage. Please contact the Benefits Office should you have any questions regarding USERRA continuation coverage.

NOTE: Unlike COBRA continuation coverage, if you do not elect USERRA continuation coverage for your dependents, they cannot separately elect to continue coverage. Also note that you (and any eligible dependents covered under HSBP on the day the leave started) may also be eligible to elect COBRA continuation coverage when you lose coverage due to military service. However, the continuation coverage provided pursuant to USERRA is an alternative to COBRA and, therefore, the two continuation periods will not run consecutively. Please review the COBRA section of this SPD for additional information.

After Discharge from the Armed Forces

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage under HSBP reinstated when you return to covered employment with a participating employer following your discharge (not less than honorably) from the uniformed services, provided that you return to employment within:

- Ninety (90) days from the date of discharge, if the period of service was 180 days or more; or
- Fourteen (14) days from the date of discharge if the period of service was thirty-one (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 eight (8) hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two (2) years.

If you have any questions about taking a leave, please speak directly with your participating employer. If you have any questions about how a leave of absence affects your benefits, please contact the Benefits Office.

Reinstatement of Coverage after Leaves of Absence

If your coverage ends while you are on an approved leave of absence from your participating employer other than leave taken pursuant to FMLA, New York Disability Leave, New York Paid Family Leave,

USERRA, or other statutory leave, your coverage will be reinstated on the first day of the month following your 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.

If you qualify for an approved leave of absence from your participating employer under FMLA, New York Paid Family Leave, USERRA, or other statutory leave law, and then inform your participating employer that you are not returning to work, HSBP will consider your employment as having been terminated, and your coverage will cease on the first day of the first month following the month in which your participating employer last makes a contribution on your behalf. Upon this termination of coverage, you will be eligible to elect COBRA continuation coverage.

Any period of any approved leave of absence, including a leave of absence under the provisions of the FMLA, New York Paid Family Leave, USERRA, or other statutory leave law 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 participating employer.

If you have any questions about taking a leave, please speak directly with your participating employer. If you have any questions about how a leave of absence affects your benefits, please contact the Benefits Office.

CHILD CARE BENEFIT

HSBP will reimburse eligible employees up to $3,500 per household per calendar year (January 1 - December 31) for child care expenses that qualify for favorable tax treatment under Internal Revenue Service (IRS) Publication 503. Subject to the eligibility criteria below, you may receive the Child Care Benefit for calendar year(s) in which you are only on payroll for part of the calendar year (i.e., July through December of PGY 1 and January through June of PGY 3); such employees might have the opportunity to apply and receive this benefit for each of the four calendar years that their three-year residency program might span.

IRS Publication 503 can be found at http://www.irs.gov/pub/irs-pdf/p503.pdf.

To receive the Child Care Benefit, you must submit a claim form with the required verification and adequate documentary proof of payment to the Benefits Office. See below. HSBP will process claims on a monthly basis.

Eligibility

In order to be eligible for the Child Care Benefit, the following must be met:

- You must be on your participating employer's payroll when the child care expenses are incurred and the child care is provided;
- The child care must be for a qualifying child who is your dependent under age 13 when the care was provided;
- Your child(ren) must be enrolled in the HSBP plan at the time care was provided and before you apply for reimbursement.
- The child must have lived with the employee for more than half the year; in the case of a newborn, the child must have lived with the employee for more than half the time they were alive in the calendar year.
- The child care expenses must have allowed you (and your spouse, if filing jointly) to work during the period for which you claim reimbursement; the IRS considers full-time students or persons not able to care for themselves the equivalent of working; and
- Child care provided in care centers with more than 6 children must be licensed.

Note that IRS Publication 503 contains specific eligibility criteria that applies to divorced or legally separated spouses or those living apart that HSBP applies.

Time to File Claims

For dates of service on or after July 1, 2024: claims must be submitted within one year from the date of service for the child care expenses.

For dates of service before July 1, 2024: claims must be submitted within the same calendar year as the date of service for the child care expenses (i.e., by December 31st).

Types of Eligible Caregivers

Expenses for the following types of caregivers are eligible for reimbursement under this benefit:

Pre-School
Nursery School
Childcare Facility
Before School Program
After School Program

Child care programs below kindergarten
Recreational Day Camp
Au Pair
Babysitter or Nanny
Housekeeper or other home aid professional
Child care at your home or another residence
Child care provided by a family member who is not your dependent, your spouse, and is over the age of 19

Exclusions

The following is not eligible for reimbursement:

- Expenses to attend school (kindergarten or above) or overnight camp.
- Expenses where the child care provider may be claimed as a dependent for tax purposes by you or your spouse (if filing jointly), is under the age of 19, is the parent of the child, is yourself or your spouse.

How to Make a Claim

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits, or on the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- Entire claim form must be completed in full by the employee.
- A separate claim form must be submitted per dependent.
- Employee must provide the childcare provider's name, address, telephone number, and Social Security Number or tax identification number. If the provider is a tax-exempt organization, no tax identification number is required and you can enter "tax exempt" on the form.
- Employee must provide the name, date of birth, and Social Security Number or tax identification number of the child(ren).
- Proof of payment in the form of cash receipt, invoice showing payment, canceled check(s), or credit card statement; proof of payment must show date(s) of service. If the provider is a day care center that provides care for more than six (6) children, the receipt must include the provider's license number.
- Your child(ren) must be enrolled in the HSBP plan at the time that the care was provided and before you apply for reimbursement.
- **For dates of service on or after July 1, 2024:** claims must be submitted within one year of the date of service for the child care expenses.
- **For dates of service before July 1, 2024:** claims must be submitted within the same calendar year as the date of service for the child care expenses (i.e., by December 31st).

Assistance In Finding Child Care Services

If you need assistance in finding child care, you may wish to contact the New York City Care Resource & Referral (NYC CCR&R) Consortium, which actively works to improve and increase access to a range of early learning programs including child care, Head Start and Pre-K. For more information call 888-469-5999 or visit www.nycccrr.org.

You may not claim a credit or deduction with the IRS for any expenses for which HSBP provides reimbursement.

Please note that the Benefits Office will not be able to provide tax advice. Refer to your accountant or tax preparer for tax assistance.

CONTINUING LEARNING PROGRAM (CLP)
(INSURED BY HSBP)

Reimbursement Benefit

The Fund will reimburse employees a maximum of $1,500 every three years based solely on their paid PGY level for qualified CLP costs. **However, you can split the $1,500 among one or more CLPs during your basic residency, or during each fellowship or chief residency year.**

PGY level	Maximum reimbursement
1-3	$1,500
4-6	$1,500
7-9	$1,500

No employee can receive more than the maximum allowable amount of $1,500 during any Plan Year. You cannot seek advance reimbursements if you already exhausted your $1,500.

Eligible for Reimbursement if Work-Related and Medical in Nature

To be eligible for CLP reimbursement, you must submit proof of attendance and payment within one year from the date of purchase.

The following CLPs may be eligible for reimbursement provided that they are work-related and medical in nature:

- Medical Conferences
- Board Review Courses
- Online courses

Conferences or courses attended after you terminate your residency program are covered if you pay for the CLP while on your participating employer's payroll and attend the CLP within six (6) months of termination of your employment with a covered employer. You must still provide documentation illustrating proof of attendance.

Example:

- Paid for a conference or course on May 5th while still on your participating employer's payroll.
- You graduated on June 30th.
- You can attend the course or conference on October 21st.

The costs of registration and tuition are reimbursable. In order to be reimbursed, you must provide proof of payment and proof of attendance to the Benefits Office. Examples of acceptable proofs of attendance include ID badges, program agendas, or certificates of completion from the course or conference.

The following expenses may be eligible for reimbursement when incurred in conjunction with an eligible CLP:

- The costs of transportation between your home and the CLP location (travel by airplane, bus, or car);
- Taxi or bus fares (for transportation between the airport or a hotel and the CLP location);
- Car (mileage, tolls, parking and costs of rental, if necessary);

- Lodging/Hotels (if travel is overnight or long enough that you need to stop for sleep or rest);
- Posters / Abstract Submission; and
- Meals and incidental expenses when traveling to conferences away from home (including amounts for food, beverage and tips)

HSBP will reimburse your actual, documented expenses for the items above up to the limits below (if any). If you spend more than the limits below, you will not be reimbursed the difference between the limits and the amount you spent. The limits are:

Meals and incidental expenses: up to $15/day for breakfast; up to $25/day for lunch: up to $35/day for dinner;

All lodging/hotel expenses must be reasonable.

Note: you are responsible for receiving approval from your employer for leave, if necessary, to attend a CLP.

Not Eligible for Reimbursement: the following courses are not eligible for reimbursement:

- Advanced Trauma Life Support (ATLS)
- Pediatric Advanced Life Support (PALS)
- Advanced Cardiac Life Support (ACLS)

Reimbursement from Your Employer

If your employer also provides a conference and/or course reimbursement, your employer will reimburse you first and HSBP will reimburse you for the balance, up to your remaining maximum allowable amount, for any outstanding balance. For example, if your employer reimburses you $500 of a $1,500 conference fee, HSBP will reimburse you for the balance, in this case, $1,000, provided you have $1,000 remaining of your maximum allowable amount.

Rotations Between Employers

If you are rotating between a CIR hospital and a non-CIR hospital, CLPs should be paid for **and** attended while on your employer's payroll. If attendance or payment is not possible for the employee because of a rotation schedule, a written appeal outlining the facts should be addressed to the Board of Trustees when you submit your claim.

Attending a Conference After Graduation

To be eligible for reimbursement:

- You must pay for a conference while on payroll before you terminate off your employer's payroll; and
- The conference must be scheduled no more than six (6) months after graduation.

For example: if you're graduating on June 30th and pay for a conference prior to graduating on June 30th, you can attend a conference between July and December of that year and seek reimbursement.

Claims for reimbursement must be submitted within a year of the date of purchase.

How to Make a Claim

To file a claim for reimbursement, you must fill out a claim form and submit it to the Benefits Office within one year from date of payment.

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

In order to apply for reimbursement of CLP expenses, please following the procedure below:

- Submit documents showing all eligible expenses to your employer and retain two copies, one for your records and one to submit to the Benefits Office.
- Once your claim is processed by your employer, complete the claim form. Submit the claim form with the CLP agenda or program (copies are acceptable) and copies of all receipts to the Benefits Office. If a payment is received from your employer, also submit a copy of the claim and a copy of the check.
- Receipts with proof of payment and dates of purchase must be submitted for all expenses claimed, **including meals** (copies of receipts will be accepted as proof of expense; original receipts may be requested.) Eligible expenses will be reimbursed only up to the maximum reimbursable limits set forth above. Expenses incurred in conjunction with an eligible CLP (such as meals, lodging/hotels) will not be reimbursed without proof of registration and attendance at an eligible CLP.
- No claims will be processed prior to attendance at a CLP or prior to date of online/board review course.
- All claims must be submitted to the Benefits Office within one year from the payment date of the CLP. Claims submitted after one year will be denied.
- Note: you are responsible for receiving approval from your employer for leave, if necessary, to attend a CLP.

DENTAL BENEFITS
(INSURED BY GUARDIAN DENTAL INSURANCE – GROUP #417732)

HSBP's Dental Benefits help you and your eligible dependents pay for dental care. Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA) as they are provided under a separate contract. The HSBP has contracted with Guardian Dental Insurance to provide you with access to networks of dentists and dental services.

Guardian Life Insurance Company administers the dental plan which has two options from which you can choose for yourself and your eligible dependents. Managed DentalGuard (MDG) is a Dental Managed Organization plan which functions much like an HMO does for health care. The other dental plan is called DentalGuard Preferred (DGP) which is a Preferred Provider Organization (PPO) which will allow you to use either a dentist who is participating in the dental plan's network or any dentist you choose, whether or not he or she is participating in the PPO network with Guardian.

Either dental plan will cover many of the dental expenses incurred by you and those of your dependents who are covered for dental benefits under this dental plan. However, the most economical plan for you and your dependents will be the MDG dental plan, while the DGP dental plan will allow you greater choice of dentists. If you choose the DGP dental plan, your costs will be less if you choose dentists who are participating in the Guardian PPO network over those who are not.

All New York State employees have a choice between a Managed DentalGuard (MDG) or DentalGuard Preferred (DGP). You must choose one dental plan, either Managed DentalGuard or DentalGuard Preferred. However, if employees do not elect MDG or DGP within thirty (30) days of enrollment, employees with addresses located in New York, New Jersey, and Connecticut will be defaulted to the MDG dental plan; employees with addresses located outside of New York, New Jersey, and Connecticut will be defaulted to the DGP dental plan. The following is a summary of the benefits offered by each.

DentalGuard Preferred PPO and Managed DentalGuard DHMO Comparison Information

Your Plan Options

Dental Health Maintenance Organization (DHMO) plans typically cost less, but require you to see the in-network dentist you select. Preferred Provider Organization (PPO) plans allow you the freedom to see any dentist, with greater savings when you stay in-network.

FEATURES	PPO	DHMO
Choice of dentists	Freedom to visit any dentist, but save more with in-network dentists	Must see selected in-network dentist for benefits to apply
Payment for care	Pay an annual deductible and the plan pays a percentage of your costs once it's met. Costs are not known in advance.	You pay a set co-pay at each visit, so you know exactly what it will cost.
Deductible	Yes	No
Annual Maximum	Limited to how much the plan will cover each year	No annual maximum
Coverage in-network	Yes	Yes
Coverage out-of-network	Yes	No
Emergency Coverage Out-of-Area	Yes	Limited
Dentists Credentialing Standards	Yes	Yes
Ability to Change Dentists	Unlimited	Limited to once per month
Insurer's Payments to Dentists based on:	• Fee schedule for in-network • Reasonable and customary (R & C) for out-of-network	• Fee schedule for specialists

Preferred Provider Organization (PPO) Plans

- Access the entire Guardian network of providers and dentists outside it when necessary
- Pay a monthly premium and your plan covers a percentage of dental costs after a deductible is met
- Visit any dentist— no referrals needed for specialists—but you'll save the most when visiting a dentist in-network
- PPO plans have an annual maximum for what is covered each year

Dental Health Maintenance Organization (DHMO) Plans

- Members choose one dentist (or dental office) as provider
- Your primary dentist can refer you to a specialist as needed. No annual maximum and no deductible - you pay a copayment, based on the dental service you received.
- Affordable for both individuals and families because many diagnostic and preventive services may not have copayment. Note that if you go to another dentist you could be responsible for paying the entire bill, so choosing the right dentist is important.

Underwritten by: First Commonwealth Insurance Company - (IL), First Commonwealth of Missouri - (MO), First Commonwealth Limited Health Services Corporation - (IN), First Commonwealth Limited Health Services Corporation of Michigan - (MI), , Managed Dental Care - (CA), Managed DentalGuard, Inc. - (NJ, OH, TX), The Guardian Life Insurance Company of America - (CO, FL, NY). All First Commonwealth, Managed DentalGuard, Inc. and Managed Dental Care entities referenced are wholly-owned subsidiaries of The Guardian Life Insurance Company of America. Products are not available in all states. Limitations and exclusions apply. Plan documents are the final arbiter of coverage and are a summary only. Dental Policy form # GP-1-DG2000. Policy Form #GP-1-MDC.

File #2014-10762 Exp. 8/16

The Guardian Life Insurance Company of America®(Guardian), 7 Hanover Square, New York, NY 10004. GUARDIAN® and the GUARDIAN G® logo are registered service marks of The Guardian Life Insurance Company of America and are used with express permission.

Guardian decides: (a) the requirements for services to be paid; and (b) what benefits are to be paid by either dental plan. Guardian also interprets how the dental plan is to be administered. What Guardian covers and the terms of coverage are explained below and within your Guardian Dental Certificate of Coverage.

MANAGED DENTALGUARD (MDG)

This plan is designed to provide quality dental care while controlling the cost of such care. To do this, this dental plan requires employees and dependents to seek dental care from participating dentists that belong to the MDG network. Except for emergency dental services, in no event will Guardian pay for dental care provided by a non-participating dentist.

The MDG network is made up of participating dentists in the employee's geographic area. A "participating dentist" is a dentist that has an MDG participation agreement in force with Guardian. When an employee enrolls in this dental plan, he or she will get information about Guardian's current participating general dentists. Each employee and dependent must select from this list of participating general dentists a primary care dentist (PCD) who will be responsible for coordinating all of the employee's and dependent's dental care. If an employee or dependent does not select a dentist, they will be assigned a dentist near their home address. Each employee and dependent can choose different PCDs. **If the employee's address is outside of the tri-state area they must select a PCD within the tri-state area or select the Dental Guard Preferred plan; Guardian cannot automatically default you to the provider closest to your home address**.

For instructions to find a Managed DentalGuard dentist, visit https://www.cirseiu.org/wp-content/uploads/2017/12/Find-a-Provider-App-Dental.pdf.

If the employee does not complete an enrollment form within thirty (30) days from their date of hire, they will only be able to select the MDG plan until the next Open Enrollment Period. After enrollment, the employee and dependents will receive an MDG ID card. An employee or dependent must present this ID card when he or she goes to his or her PCD. All dental services covered by this dental plan must be coordinated by the PCD whom the member selects and is assigned to upon enrolling in this dental plan. What Guardian covers is based on all the terms of this dental plan. Read this dental plan carefully for specific benefit levels, exclusions, coverage limits, and patient charges.

Choice of Dentists

An employee and dependent may select any available participating general dentist as his or her PCD. A request to change PCDs must be made directly with Guardian. Any such change will be effective the first day of the month following approval. Guardian may require up to thirty (30) days to process and approve any such request. All fees and patient charges due to the employee's or dependent's current PCD must be paid in full prior to such transfer.

Guardian compensates participating general dentists through an advance payment agreement by which they are paid a fixed amount of money each month based upon the number of members that select them as their PCD. In addition, Guardian may make supplemental payments on a limited number of specific dental procedures, office visit payments, and annual guarantee payments. These are the only forms of compensation the participating general dentist receives from Guardian. The dentists also receive compensation from dental plan members who may pay an office visit charge for each office visit and a defined patient charge for specific dental services. The schedule of patient charges is shown below.

Specialty Referrals

An employee or dependent's PCD is responsible for providing all covered services. However, certain services may be eligible for referral to a participating specialist. Guardian will pay for covered services for specialty care, less any applicable patient charges, when such specialty services are provided in accordance with the specialty referral process described below.

Guardian compensates our participating specialists the difference between their contracted fee and the patient charge shown in the *Covered Dental Services and Patient Charges* section. This is the only form of compensation that participating specialists receive from Guardian.

ALL SPECIALTY REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY GUARDIAN; AND (B) COORDINATED BY AN EMPLOYEE OR DEPENDENT'S PCD. ANY EMPLOYEE OR DEPENDENT WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

Emergency Dental Services

Guardian provides for emergency dental services twenty-four hours a day, seven days a week, to all employees and dependents. An employee or dependent should contact his or her selected and assigned PCD, who will make arrangements for such care. If an employee or dependent is unable to reach his or her PCD in an emergency during normal business hours, he or she must call Guardian's Member Services Department for instructions. If an employee or dependent is unable to reach his or her PCD in an emergency after normal business hours, the employee or dependent may seek emergency dental services from any dentist. Then, within two (2) business days, the employee or dependent should call Guardian to advise of the emergency claim. The employee or dependent must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her PCD. This must be done within ninety (90) days, or as soon as is reasonably possible. We will reimburse the employee or dependent for the cost of the emergency dental services, less any patient charge which may apply.

Out-Of-Area Emergency Dental Services

If an employee or dependent is more than fifty (50) miles from his or her home and emergency dental services are required, he or she should seek care from a dentist. Then he or she must file a claim within ninety (90) days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating dentist. The statement must list all services provided. Guardian will reimburse the employee or dependent within thirty (30) days for any covered emergency dental services, up to a maximum of $50.00 per incident, after payment of any patient charge which may apply.

Covered Dental Services and Patient Charges

The services covered by this dental plan are named in the Summary of Dental Benefits for Managed DentalGuard and DentalGuard Preferred Plans below. If a procedure is not on this list, contact Guardian Dental to verify coverage before receiving services. All services must be provided by the employee's or dependent's PCD.

The employee or dependent must pay the listed Patient Charge. Guardian covers the rest of the Participating Dentist's charge for the service. The benefits Guardian provides are subject to all the terms of this dental plan, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions. These Patient Charges are only valid for covered services rendered by Participating Dentists in the State of New York.

See Summary of Dental Benefits for Managed DentalGuard and DentalGuard Preferred Plans below on page 29.

Alternative Procedures

General Guidelines for Alternative Procedures

There may be a number of accepted methods of treating a specific dental condition. When an employee or dependent selects an alternative procedure over the service recommended by the PCD, the employee or dependent must pay the difference between the PCD's usual and customary charge for the recommended service and the alternative procedure. He or she will also have to pay the applicable patient charge for the recommended service.

When the PCD recommends a crown, the alternative procedure policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The employee or dependent must pay the applicable patient charge for the crown actually placed. The employee or dependent must pay the added cost of high noble metal, if high noble metal is selected.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the employee or dependent before treatment begins. The PCD should present the employee or dependent with a treatment plan in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

How to Make a Claim

When using a PCD, there is no need to file a claim; the PCD will file the claim on the employee or dependent's behalf.

DENTALGUARD PREFERRED (DGP)

This dental plan's Dental Preferred Provider Organization (PPO)

DentalGuard Preferred is the alternate dental plan to Managed DentalGuard. DentalGuard Preferred is a Preferred Provider Organization which allows the employee and eligible dependents greater freedom in choice of dentists, but the employee and eligible dependents will also incur greater costs for the services rendered. This dental plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the dental plan encourages a covered person to seek dental care from dentists and dental care facilities that are under contract with Guardian's dental Preferred Provider Organization (PPO).

This dental plan usually pays a higher level of benefits for covered treatment furnished by a preferred provider. Conversely, it usually pays less for covered treatment furnished by a non-preferred provider.

The DentalGuard Preferred is made up of preferred providers in an employee's or dependent's geographic area. Use of the DentalGuard Preferred is voluntary. An employee or dependent may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

When an employee enrolls in this dental plan, he or she and his or her dependents receive a dental plan ID card and information about current preferred providers.

An employee or dependent must present his or her ID card when he or she uses a preferred provider. Most preferred providers prepare necessary claim forms for the employee or dependent and submit the forms to Guardian. Guardian sends the employee or dependent an explanation of this dental plan's benefit payments, but any benefit payable by Guardian is sent directly to the preferred provider.

What Guardian pays is based on all of the terms of this dental plan. Please read this dental plan carefully for specific benefit levels, deductibles, payment rates and payment limits.

An employee or dependent may call Guardian at the number shown on his or her ID card should he or she have any questions about this dental plan.

<u>COVERED CHARGES</u>

If an employee or dependent uses the services of a preferred provider, covered charges are the charges listed in the fee schedule the preferred provider has agreed to accept as payment in full for the dental services listed in this dental plan's List of Covered Dental Services.

If an employee or dependent uses the services of a non-preferred provider, covered charges are reasonable and customary charges for the dental services listed in this dental plan's List of Covered Dental Services.

To be covered by this dental plan, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

Guardian may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By "reasonable," Guardian means the charge is the dentist's usual charge for the service furnished. By "customary," Guardian means the charge made for the given dental condition isn't more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this dental plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planning. If the scaling and root planting is performed one or two weeks prior to the osseous surgery, Guardian may only pay benefits for the osseous surgery.

Guardian only pays benefits for covered charges incurred by an employee or dependent while he or she is insured by this plan. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while an employee or dependent is insured, Guardian will only pay benefits for services which are completed within thirty-one (31) days of the date his or her coverage under this dental plan ends.

See Summary of Dental Benefits for Managed DentalGuard and DentalGuard Preferred Plans below on page 29.

Alternate Treatment

If more than one type of service can be used to treat a dental condition, Guardian has the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by Guardian. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

Note: An employee or dependent may be eligible for a rollover of a portion of his or her unused Plan Year Payment Limit for Non-Orthodontic Services. See the following:

MAXIMUM ROLLOVER PROVISIONS APPLYING ONLY TO DENTALGUARD PREFERRED MEMBERS

Maximum Rollover: With Maximum Rollover, Guardian will roll over a portion of each employee's or dependent's unused annual maximum, called the Maximum Rollover Amount, into his or her Maximum Rollover Account (MRA). The MRA can be used in future years, if an employee or dependent reaches the dental plan's Annual Maximum. Maximum rollover does not apply to Orthodontic Services.

Even better, if an employee or dependent uses the services of Preferred Providers exclusively during the benefit year, we'll increase the amount credited to his or her MRA to the In-network Only Maximum Rollover Amount.

To qualify, an employee or dependent must submit a claim and not exceed the paid claims Threshold during the benefit year. The employee and each dependent maintain separate MRAs based on their own claim activity. Each employee's or dependent's MRA may not exceed the MRA limit.

PLAN ANNUAL MAXIMUM	THRESHOLD	MAXIMUM ROLLOVER AMOUNT OUT OF NETWORK	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLL-OVER ACCOUNT LIMIT

$1,000	$500	$250	$350	$1,000

- An employee or eligible dependent joining the plan as a new entrant with three (3) months or less remaining in the Plan Year: the MRA accumulation will begin as of the first full Plan Year. (Example: an employee joining on July 1, 2022, claim activity in 2023 will be used and applied to MRAs for use in 2024).
- Your non-network service charges will be paid for only up to the maximum fee level established with our contracted network dentists. Any amount that is charged over the fee schedule is the responsibility of you, the patient.
- Guardian has contracted with dental providers to provide discounts off services and procedures to Guardian dental plan members. To locate a provider, please reference the On-Line Provider Directory at www.GuardianLife.com.
- Pre-determination Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable.

How to Make a Claim

You can find the reimbursement claim form for DGP benefits on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

Mail claims to:

Guardian
P. O. Box 2459
Spokane, WA 99210-2459

<u>DentalGuard General Limitations and Exclusions:</u>

This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles may apply for some options. The dental plan does not pay for: oral hygiene services (except as covered under preventive services), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payer or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The dental plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontics, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage.

Special Limitation: Teeth lost or missing before a covered person becomes insured by this dental plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he or she became insured by this dental plan. Guardian won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the employee or dependent became insured by this dental plan.

<u>Guardian Customer Service</u>

For additional information about dental benefits, call Guardian Member Services at (888) 618-2016.

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered by This plan

An employee or dependent under this dental plan can receive discounts on certain services not covered by this dental plan, as described below, if:

(a) he or she receives services or supplies from a dentist that is under contract with DentalGuard PPO network; and

(b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the DentalGuard Preferred network.

The services described in this provision are **not** covered by this dental plan. The employee or dependent must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this dental plan, access to the network discounts ends.

Discounts on Services Not Covered Due to Contractual Provisions

If an employee or dependent receives dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of DentalGuard Preferred network, even if such services are not covered by the dental plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions, such as dental implants.

Summary of Dental Benefits for Managed DentalGuard and DentalGuard Preferred Plans

Dental Plan	**Managed DentalGuard**	**Dental Guard Preferred with PPO Providers**	
	In-Network *Only*	In-Network	Out of Network
	Amount you pay You must pay a copay for each covered procedure	You must pay coinsurance for each covered procedure that the Plan pays at less than 100%	Plan pays a percentage of the Reasonable and Customary amount; you must pay for any additional amount charged by the provider
Deductible	No Deductible	$0 Family limit of 3	$25 Family limit of 3 Deductible waived for preventive services
Annual Maximum Benefit	Not applicable	$2,000 Combined In-Network and Out-of-Network maximum of $1,000 with an additional $1,000 of benefit In-Network	$1,000
Maximum Rollover Rollover Threshold Rollover Amount Rollover In-network Amount Rollover Account Limit	Not applicable	Yes $500 $250 $350 $1,000	

Lifetime Orthodontia Maximum	Not applicable	$1,800 per person	
Office Visit Copay	$0	None	
Dependent Age Limit	29	29	
Procedures			
<u>Preventive Care</u> Cleaning (prophylaxis)[1] Fluoride Treatments Oral Exams Sealants (per tooth) X-Rays	 $0 (2 visits/12 months) $0 (under 18) $0 $0 $0	 100% (every 6 months) 100% (under 14) 100% 100% 100%	 100% (every 6 months) 100% (under 14) 100% 100% 100%
<u>Basic Care</u> Anesthesia[2] Fillings[3] Perio Surgery Periodontal Maintenance[1] Repair and Maintenance of Crown, Bridges and Dentures Root Canal Scaling and Root Planning (per quadrant) Simple Extractions Surgical Extractions	 Not Covered $0 $380 $0 (once every 3 to 6 months) $88-$120 $0-$270 $0 $0 $0-$160	 100% 100% 100% 100% (once every 6 months) 100% 100% 100% 100% 100%	 80% 80% 80% 80% (once every 6 months) 80% 80% 80% 80% 80%
<u>Major Care</u> Bridges and Dentures Inlays, Onlays, Veneers[4] Single Crowns	 $362-$400 $256-$304 $316	 60% 60% 60%	 50% 50% 50%
Orthodontia (adults & children)	$2,425 (limit of one course of treatment per person per lifetime)	60%	60%

This is only a partial list of dental services. Your Guardian Dental Certificate of Coverage will show exactly what is covered and excluded.

[1]The total number of cleanings and periodontal maintenance procedures are combined in a 12-month period.

[2]General Anesthesia – restrictions apply.

[3]For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings

[4]For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material.

REQUIRED DISCLOSURE STATEMENT For Group Plan No.: G-00417732-HC

This section is a short summary of the benefits this dental plan provides. These benefits, including any exclusions and limitations, are fully explained in the Guardian Dental Certificate of Coverage which should be read along with this Summary Plan Description for a complete description of your dental benefits. Please contact the Benefits Office for more details. This dental plan provides the following health insurance benefits: Dental Expense Insurance (defined as Dental Insurance by the New York State Insurance

Department). This dental 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. For further information, review your Guardian Dental Certificate of Coverage. You may also request a copy of the Guardian Dental Certificate of Coverage from the Benefits Office.

HEARING AID BENEFIT
(INSURED BY HSBP)

An employee, spouse or domestic partner and eligible dependent is eligible for services provided by EPIC Hearing Health Care (EPIC Hearing) or reimbursement to cover the cost of a hearing aid outside of EPIC Hearing. The reimbursement maximum is $5,000 per ear per lifetime.

Eligibility:

You are eligible for this benefit if you are a New York City Health + Hospitals, Westchester Hospital, CIR or Benefits Office employee or an eligible dependent.

Using an In-Network EPIC Hearing Provider:
Epic Website: https://www.epichearing.com/home

To use this benefit, contact EPIC Hearing toll free at 866-956-5400 and identify yourself as a **CIR-House Benefits Plan Member**. EPIC personnel will register you and obtain your CIR Member ID* to confirm eligibility with the Benefits Office. Once eligibility is confirmed, a referral will be issued to an audiologist closest to your home or work. EPIC will notify the audiologist of the patient referral and mail you a copy for your records. The audiologist will evaluate the hearing and submit their audiometric results with hearing aid prescription to EPIC. You will receive a plan booklet outlining all plan services and pricing. When you visit your EPIC Hearing provider, all benefits will be coordinated for you, and you will only need to pay for services that exceed the **$5,000 per ear lifetime limit**. You will **not** need to file a claim for reimbursement. You may also choose to use a provider outside of the EPIC Hearing network. See below for information about how to submit a claim for reimbursement.

You and/or your eligible dependents are entitled to a 60-day trial period for the device. Once you accept the device at the completion of the trial period, EPIC will submit a claim to the Benefits Office for payment.

*Please note: You may find you CIR Member ID on your optical card from Davis Vision. If you do not have your card or not eligible to receive the card, please contact the Benefits Office, Monday-Friday, 9am-5pm (EST) (p) 212-356-8180 or via email at benefits@cirsbenefitfunds.org.

How to Make a Claim

You may also use this hearing aid benefit outside of the EPIC Health network subject to the $5,000 lifetime limit per ear.

To file a claim, you must fill out a claim form and submit it to the Benefits Office within one year from date of purchase.

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- A separate claim form must be submitted per patient.
- The need for a hearing aid must be approved by a certified audiologist and a letter from the audiologist must be submitted with the original bill.
- The bill must state the provider's name, address and phone number, patient's name and address, services rendered, date of service and amount of purchase.
- No Explanation of Benefits (EOB) is required to be submitted with the claim form.
- Claims must be submitted within one (1) year from the date of purchase.
- HSBP reserves the right to request the original proof of payment.

IDENTITY THEFT MONITORING AND PROTECTION BENEFIT
(INSURED BY IDENTITYFORCE)

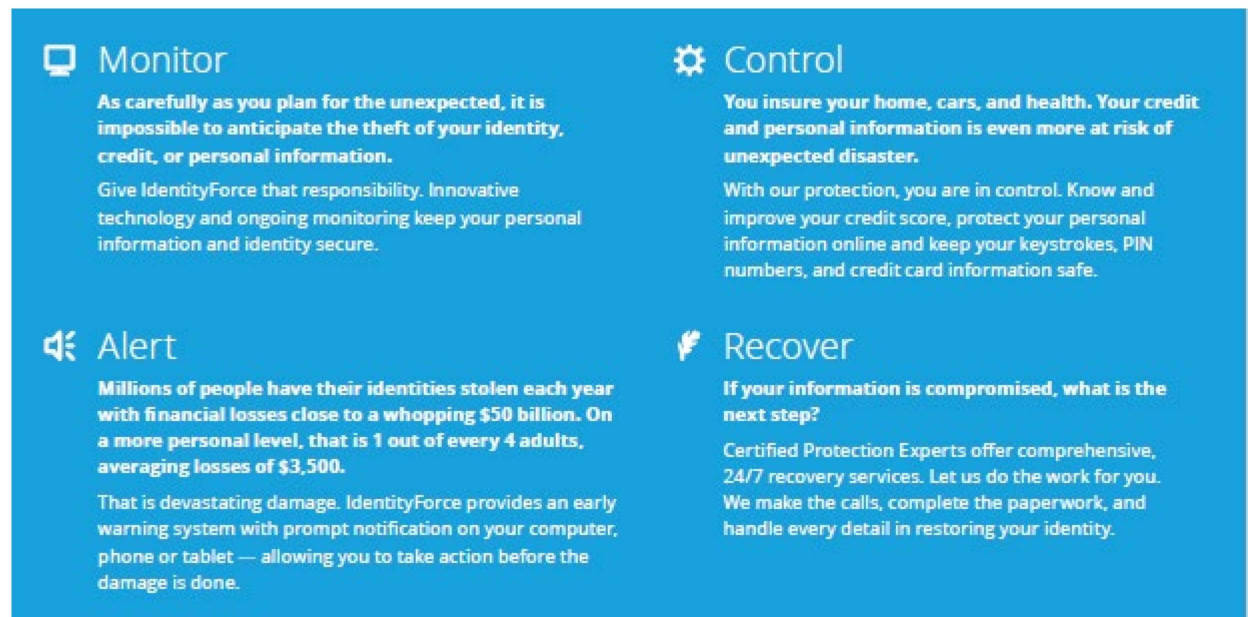
All New York City Health + Hospitals employees are eligible for a FREE subscription to IdentityForce while on payroll. Spouses, domestic partners and dependents are not eligible for this benefit. However, spouses, domestic partners, and dependents can register for a discounted self-pay rate of $7.50 per person per month.

The IdentityForce program:

- Continuously monitors your personal data to keep it secure
- Warns you before identity theft strikes with alerts on your computer, phone or tablet
- Offers comprehensive, 24/7 recovery services if identity theft does strike
- Makes calls, completes paperwork, and handles every detail to restore your identity
- Covers unlimited dependent children age 25 and under through the "Child Watch" program
- Sends fraud alerts
- Monitors your data on the dark web

To register for this free benefit, call IdentityForce Monday through Friday at 1-877-694-3367 or register via the web at www.identityforce.com.

Please note, after this benefit terminates when your employment ends, employees have the option to self-pay for continued services. Prior to the termination of your employment, contact IdentityForce Member Services at 1-877-694-3367 to “port” this benefit and switch to self pay via credit card. If your account is cancelled before you switch to a self-pay plan, you may need to re-enter your monitored information.



IdentityForce.
A Sontiq™ Brand

Employee Benefit Plans

Easy to Enroll

1. Enroll along with other voluntary benefits through your employer.
2. Receive confirmation email. If you do not receive the email, please check your spam folder.
3. Click on link in confirmation email to complete registration and access your Identity Protection Dashboard.

Questions?

Call Member Services at 877.694.3367

Protect What Matters Most™

#1 Rated Consumer ID Theft Plans

As seen on CNBC and U.S. News & World Report

Plan Coverage IdentityForce service payroll deduction pricing — Monthly	UltraSecure Gold
Employee (includes ChildWatch*)	**Paid by Employer**
Family (includes ChildWatch*)	**$7.50**

*ChildWatch | Both Employee and Family plan options include unlimited dependent children, age 25-years-old and under, living in the same household. Dependent children will be enrolled in ChildWatch, an identity protection product specifically designed for minors and young adults. Identity protection enrollment is limited to employees and their eligible dependents. At least one adult membership is required to receive ChildWatch.

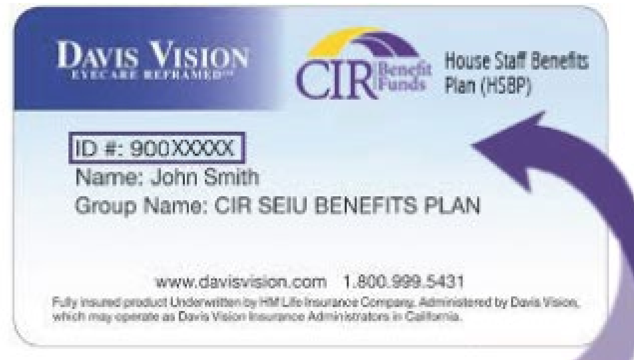
Plan Features		UltraSecure Gold
MONITOR		
Dark Web Monitoring (includes the following monitoring options:)		●
Account Takeover Monitoring	NEW	●
Address Monitoring		●
Bank Account Number Monitoring		●
Compromised Credentials Monitoring	NEW	●
Credit & Debit Card Account Number Monitoring		●
Driver's License Monitoring		●
Email Address Monitoring		●
Medical Insurance ID Monitoring		●
Passport Number Monitoring		●
Phone Number Monitoring		●
Social Security Number Monitoring		●
Fraud Alert Reminders		●
ALERT		
Identity Threat Alerts		●
CONTROL		
Medical ID Fraud Protection		●
Mobile App		●
Mobile Attack Control	NEW	●
Secure My Network (VPN)	NEW	●
Two-factor Authentication		●
Lost Wallet Assistance		●
RECOVER		
Identity Restoration Specialist		●
24/7 U.S. Based Support		●
CREDIT		
Credit Report Monitoring (Daily)		1 Credit Bureau

ABOUT SONTIQ

Sontiq is a high-tech security and identity protection company arming businesses and consumers with award-winning products built to protect what matters most. Sontiq's brands, EZShield and IdentityForce, provide a full range of identity monitoring, restoration, and response products and services that empower customers to be less vulnerable to the financial and emotional consequences of identity theft and cybercrimes. Learn more at www.sontiq.com or engage with us on Twitter, Facebook, LinkedIn, or YouTube.

© 2020 Sontiq, Inc. All other trademarks or trade names are properties of their respective owners. All rights reserved.

VISION BENEFIT
(INSURED BY HSBP)



Vision benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (PPACA). HSBP has contracted with Davis Vision to provide you with access to networks of vision services.

In-Network Benefit

The HSBP offers a comprehensive vision benefit through Davis Vision. When you and your eligible dependent(s) use your benefit In-Network you will be entitled to the following benefits once per Plan Year:

- Free eye exam
- Lenses (see chart below for options and co-pay amounts)
- Frames: if you choose a frame that is NOT in the Davis Vision collection, you will be given a $150 allowance toward any frame from the participating provider plus 20% off the balance*
- Contact Lenses (in lieu of eyeglasses) (see chart below for options, co-pay amounts, and potential discounts)
- Contacts and lens fitting:
  - Collection Contacts and lens fitting covered in full
  - Non Collection Contacts: 15% discount off the balance and fees* (see chart below for more info)

* Some limitations apply to additional discounts; discounts not applicable at all in-network providers

Participating Providers

To locate a provider in the Davis Vision network, log on to the *Open Enrollment* section at davisvision.com and enter client code 2200. To use your benefit In-Network, present your Davis Vision Member ID card or give the provider our client code (2200) and your first and last name.

Other Vision Benefits

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 (877) 923-2847.

Out-of-Network Benefit

You may receive services from an Out-of-Network provider who is not in the Davis Vision network; however, you will receive the greatest value when you use an In-Network provider. If you choose an Out-of-Network provider, you will receive a maximum of $50 per Plan Year toward an eye exam and $150 toward materials. You must pay the provider directly and file a claim with Davis Vision to be reimbursed. (This applies to eyeglasses or contact lenses).

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

Mail claims to:

Vision Processing Unit
PO Box 1525,
Latham, NY 11210

Your Davis Vision Premier Plan Benefits

Benefit Year	July 1 through June 30		
Benefit	**Frequency** Once every -	**In-network Copay**	**In-network Coverage**
Eye Examination	July 1	$0	Covered in full. *Includes dilation when professionally indicated.*
Spectacle Lenses	July 1	$0	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings.)
Frame	July 1	$0	**Covered in Full Frames:** Any Fashion, Designer or Premier level frame from Davis Vision's Collection[1] (retail value, up to $225). **OR, Frame Allowance:** $130 toward any frame from provider plus 20% off any balance[3]. No copay required. *Please Note: Safety eyewear is available in lieu of dress eyewear.*
Contact Lens Evaluation, Fitting & Follow Up Care	July 1	$0	**Davis Vision Collection Contacts:** Covered in full. **Non Collection Standard Contacts:** 15% discount[3] **Non Collection Specialty Contacts[2]:** 15% discount[3]
Contact Lenses (in lieu of eyeglasses)	July 1	$0	**Covered in Full Contacts:** From Davis Vision's Collection[1], up to: Planned Replacement: Two boxes/multi-packs Disposable: Four boxes/multi-packs **OR, Contact Lens Allowance:** $130 allowance toward any contacts from provider's supply plus 15% off balance[3]. No copay required. **OR, Visually Required Contacts:** Covered up to $210, with prior approval.

Significant savings on optional frames, lens types and coatings! Member Price

Item	Member Price
Davis Vision Collection Frames: Fashion | Designer | Premier	$0 | $0 | $0
Tinting of Plastic Lenses	$0
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Ultraviolet Coating	$0
Anti-Reflective Coating: Standard | Premium | Ultra | Ultimate	$35 | $48 | $60 | $85
Polycarbonate Lenses	$0
High-Index Lenses 1.67 | 1.74	$55 | $120
Progressive Lenses: Standard | Premium | Ultra | Ultimate	$0 | $40 | $90 | $125
Polarized Lenses	$75
Plastic Photosensitive Lenses	$65
Digital Single Vision Lenses	$0
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20 | $40
Trivex Lenses	$50
Blue Light Filtering	$15

[1] The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

[2] Including, but not limited to toric, multifocal and gas permeable contact lenses.

[3] Some limitations apply to additional discounts, discounts not applicable at all In-network providers.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. If contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through CIR SEIU House Staff Benefits Plan (HSBP). Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Frequently Asked Questions

How can I contact Member Services?
Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. | Saturday, 9 a.m.-4 p.m. | Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $50 | materials - $150.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.[/4]

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & Wellness Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notices, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

[4/]Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Fully insured product Underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

Exclusions

This benefit does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

Appealing Vision Coverage

Appeals for vision benefits must 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 (888) 343-3470 or address your complaint, grievance or appeal to:

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

In all communications about a claim, be sure to include your identification number and group number.

QUALITY IMPROVEMENT (QI)/PATIENT SAFETY EDUCATION AND TRAINING SCHOLARSHIP

HSBP is committed to providing Employees the tools to deliver the best patient care.

QI/Patient Safety Conferences

The Plan will fund a series of QI/Patient Safety Conferences and disseminate QI/Patient Safety resource information. All covered employees will be invited to attend these events and be able to access resources created. There will be no registration fee for eligible covered employees to attend these events or to access QI/Patient Safety resource information.

Patient Safety Education and Training Scholarships

The Plan provides scholarships for eligible covered employees to access approved Quality Improvement and Patient Safety sponsored programs available in the contiguous 48 United States. In order to receive these benefits, you must be pre-approved by the Plan. Once approved, employees will be eligible to receive scholarship benefits of up to $3,000 per Plan Year to cover the expenses related to registration, travel, and tuition at one Patient Safety Education and Training Program per Plan Year. **Spouses, domestic partners, and dependent children are not eligible for this scholarship.**

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

Applications to participate in this benefit will be granted on an equitable basis based on completion of the Quality Improvement Training & Education Application Form and criteria developed by the Quality Improvement Director. The application must include an explanation detailing how the applicant will present what they learned at the conference to their hospital colleagues (for example, at grand rounds, departmental presentations, or intern orientation).

<u>Who is Eligible?</u>

Only employees of HSBP participating employers who will be employed by the HSBP participating employer in the following academic year; in other words, you must have at least one academic year left in your residency or fellowship program to be eligible. Employment requiring rotation to a non-HSBP hospital will render you ineligible for this benefit.

<u>Covered Expenses Following Approval</u>

The following expenses are eligible for reimbursement when incurred in conjunction with a pre-approved QI program:

- Expenses related to program registration or tuition
- Reasonable lodging or hotel expenses (if travel is overnight or long enough that you need to stop for sleep or rest)
- The costs of transportation between your home (residency program location) and the QI location (travel by airplane, bus, or car; airplane travel subject to the restrictions below)
- Car expenses (mileage, tolls, parking and costs of rental, if necessary)
- Poster(s)/Abstract Submission(s)
- Meals and incidental expenses (including amounts for food, beverage and tips) when traveling to conferences away from home up to the following limits:
  - Up to $15 for breakfast
  - Up to $25 for lunch
  - Up to $35 for dinner

Expenses that are not covered:

- *Acela* Amtrak train or Business Class travel
- Room service
- Pay per View movies
- Alcohol and bar expenses
- Expenses for costs incurred by spouse or dependent(s)
- Other personal expenses

Submission Rules

Prior to attendance, you must first submit, and the Plan must approve, your application. See more information under the *How to Apply* section below. Applications to participate in this benefit will be granted on an equitable basis.

Once you have attended or participated in the approved event, you will have ninety (90) days to fulfill the requirements set forth in your application. These requirements are: posting your findings on the CIR Gateway site, www.qigateway.org, and presenting the content learned from the program to your department or hospital colleagues.

Finally, you must complete the reimbursement form for your eligible expenses within one (1) year of the date of purchase.

How to Apply

You can find the application form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- **You must submit your application at least six (6) weeks prior to the program date.**
- The application must include an explanation detailing how you will present what you learned at the program to your department or hospital colleagues (for example, at grand rounds, departmental presentations or intern orientation).
- If you are a first-time applicant, with your application you must submit your curriculum vitae (two-page maximum), a personal statement highlighting your interest in patient safety and why attending this program would complement that interest (one-page maximum), and a letter of support from a faculty member that highlights your leadership and patient safety engagement.
- If approved, you are responsible for receiving time off (vacation or education leave time) from your participating employer to attend or participate in these educational opportunities; this benefit will not provide any shift coverage.

Guidelines for Expenses Reimbursement:

You must receive an approval letter from the Plan prior to booking any necessary travel. All travel must be booked through UN Travel. Please see further instructions below under “Transportation Reimbursement Guidelines.”

Once you have attended the previously-approved event, the Plan will reimburse your actual, documented expenses for the items listed above under “Covered Expenses” up to the stated limits (if any). If you spend more than the limits, you will not be reimbursed the difference between the limits and the amount you spent. In order to be reimbursed, you must provide proof of attendance and proof of payment for all eligible expenses to the Benefits Office with your claim form. Examples of acceptable proofs of

attendance include ID badges, program agendas, or certificates of program completion. No claims will be processed prior to proof of attendance at the program or program completion.

Receipts must be submitted for **all** eligible purchases and date of purchase must be on receipt. Please upload **scanned copies or clear photos/images** of your receipts. The Plan reserves the right to request original receipts.

Reimbursement claims must be submitted to our office within one (1) year from date of purchase.

Transportation Reimbursement Guidelines

- Employees must travel in economy or coach class; HSBP **will not** reimburse Employees for any upgrades (example: coach to business class) or travel by Amtrak Acela train.
- Employees MUST reserve tickets by contacting **UN Travel (800) 234-8685 or (215) 922-4671**.
- Tickets purchased through UN Travel are charged directly to HSBP.
- Your travel reservation will officially be booked only when you respond to UN Travel's email within 24 hours to accept your initial itinerary and receive a confirmation message from UN Travel with your final itinerary.
- If you are traveling from a different location other than your home (your residency program location) to a conference, and the cost of the fare is more than the round-trip fare to and from your home, you will be responsible to pay the difference in the cost of travel, as determined by UN Travel, at the time of booking.
- All travel changes, such as changing departure/arrival airport or station, flight/train time, etc., must be approved in advance by UN Travel and will only be reimbursed when the change is due to work-related circumstances.
- UN Travel will need the following information from you to book:

  1. Your name as it appears on your driver's license or passport
  2. Date of birth
  3. Gender
  4. Cell phone number
  5. Email Address
  6. Departure airport or train station (city and state)
  7. Arrival and departure dates and times for travel
  8. Frequent Flyer Number and preferred airline (if any) or Amtrak Rewards number (if any)
  9. TSA Number (if applicable)

Recommended Programs

American Association of Medical Colleges (AAMC) Integrating Quality Conference
Association for Graduate Medical Education (ACGME) Annual Conference
Agency for Healthcare Quality and Research (AHRQ) Annual Conference
American College of Medical Quality (ACMQ) Annual Meeting
Annual Quality and Safety Educators Academy (QSEA)
Beyond Flexner
Institute for Healthcare Improvement (IHI) Annual National Forum on Quality Improvement in Healthcare, or other IHI events

In-Hospital Programming Online Curriculum & QI Gateway Conference
Lown Institute Annual Conference
National Association for Health Quality (NAHQ) Annual Educational Conference
National Patient Safety Foundation (NPSF) Conference
National Quality Forum (NQF) Annual Conference
Society of Teachers of Family Medicine (STFM) Annual Spring Conference
SQUIRE International Conference
Telluride Patient Safety Roundtable

SUPPLEMENTAL REIMBURSEMENTS

The following benefits are reimbursements for covered services that you have received. You must first pay for the covered services and submit an Explanation of Benefits (EOB) from your primary medical coverage for reimbursement in order to receive any of the Supplemental Reimbursement benefits. Unless specifically stated below, an EOB is required to be submitted with claim forms. You must be on your participating employer's payroll at the time that expenses are incurred.

HSBP only provides supplemental reimbursement for qualified medical expenses under Section 213(d) of the Internal Revenue Code. Generally, qualified medical expenses are those expenses that would qualify for the medical and dental expenses deduction. These are explained in Publication 502, Medical and Dental Expenses: https://www.irs.gov/forms-pubs/about-publication-502. For information regarding filing claims for a supplemental reimbursement, please see the section describing each benefit below.

Under no circumstances will HSBP reimburse you for more than your out-of-pocket expenses.

Exclusions

These benefits do not cover expenses due to:

- Services rendered by an eligible provider during a hospital confinement resulting in a room and board charge.
- Sickness covered under Workers' Compensation or similar laws.
- Services (a) furnished by or for the U.S. Government, or (b) furnished by or for any other government unless payment is legally required or (c) to the extent provided under any governmental program or law under which the individual is, or could be, covered.
- Anything not ordered by an eligible provider, or not necessary for medical care; the portion of a charge for a service in excess of the primary carriers' reasonable and customary charge (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience).
- Covered services rendered by yourself, your spouse, or, in New York State only, your domestic partner or a child, brother, sister, or parent of yourself, your spouse.
- Services received as a result of an act of war occurring while covered.
- Care that is not medically necessary.

SUPPLEMENTAL DENTAL BENEFIT - $1,000 (PER PERSON)
(INSURED BY HSBP)

The maximum benefit is $1,000 per person per Plan Year.

For Dates of Service on or after January 1, 2023

If the employee or eligible dependent is enrolled in Guardian DentalGuard Preferred, Guardian Managed DentalGuard or another dental plan, such as the spouse's ("Dental Plan"), this supplemental benefit will reimburse 100% of the coinsurance and copayment amounts paid by the employee and/or dependent for covered services. This 100% supplemental reimbursement will **not exceed the maximum per person per Plan Year of $1,000**. **Only services that are covered by your Dental Plan will be reimbursed by HSBP. Plan reimbursement will not exceed the employee or dependent's out-of-pocket costs.** Insurance deductibles paid under your primary dental plan (if any) are **not** reimbursable under this benefit.

For Example:

Amount of Dental Service Charged to Your Primary Dental Plan	Maximum Primary Plan Allowance	Amount Your Primary Plan Pays	Amount You Owe (Coinsurance or Copayment)	HSBP's Supplemental Reimbursement to You
$2,170	$875	$748.85	$126.15	$126.15

With your Dental Reimbursement Claim Form:

- **If you are enrolled in the MDG Plan**, you must attach an itemized statement of covered charges with the exact date(s), diagnosis and procedure codes for which services were rendered, along with receipts showing proof of payment and date of service.
- **If you are enrolled in DGP or another dental plan (other than MDG)**, you must attach the Explanation of Benefits (EOB) received from the plan **and** receipts showing proof of payment and date of service.

For Dates of Service before January 1, 2023

The amount of HSBP's reimbursement will depend on what dental plan you are enrolled in: 1) DentalGuard Preferred or another dental plan or 2) Managed DentalGuard. **However, the DentalGuard Preferred and Managed DentalGuard reimbursements in combination cannot exceed the $1,000 maximum reimbursement per person per Plan Year.**

- ***DentalGuard Preferred (DGP) or Another Dental Plan***

If the employee or eligible dependent is enrolled in Guardian DentalGuard Preferred or another dental plan, such as your spouse's, this supplemental benefit will reimburse 20% of the amount paid by the dental plan for covered services to the provider. **Only services that are covered by your primary plan will be reimbursed by HSBP**. This 20% supplemental reimbursement will **not exceed the maximum reimbursement per person per Plan Year of $1,000**. **Plan reimbursement will not exceed the employee or dependent's out-of-pocket costs.** Insurance deductibles paid under your primary dental plan (if any) are **not** reimbursable under this benefit.

With your Dental Reimbursement Claim Form, you must submit an itemized statement of covered charges from your primary care dentist with the exact date(s), diagnosis and procedure codes for which services

were rendered. Scanned copies of your receipts for eligible dental expenses must be submitted to the Benefits Office with the appropriate claim form.

For Example:

Amount of Dental Service Charged to Your Dental Plan	Amount Paid By Guardian DGP or Other Dental Plan to the Provider	20% of Plan Payment	HSBP's Supplemental Reimbursement to You
$404.00	$300.00	$60.00	$60.00

- ***Managed DentalGuard (MDG)***

If the employee or eligible dependent is enrolled in the Guardian Managed DentalGuard plan, this supplement will pay 20% of the employee's and/or dependent(s)' out-of-pocket costs paid for covered Managed DentalGuard services. **Only services that are covered by your Guardian MDG Plan will be reimbursed by HSBP**. This 20% supplemental reimbursement will **not exceed the maximum reimbursement per person per Plan Year of $1,000**. **Plan reimbursement will not exceed the employee or dependent's out-of-pocket costs.**

With your Dental Reimbursement Claim Form, you must submit an itemized statement of covered charges from your primary care dentist with the exact date(s), diagnosis and procedure codes for which services were rendered. Scanned copies of your receipts for eligible dental expenses must be submitted to the Benefits Office with the appropriate claim form.

For Example:

Co-Payment under MDG Plan	20% Of Co-Payment	HSBP's Supplemental Reimbursement to You
$316.00	$63.20	$63.20

How to Make a Claim

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- **If you are enrolled in the Guardian MDG Plan**, you must attach an itemized statement of covered charges with the exact date(s), diagnosis and procedure codes for which services were rendered, along with receipts showing proof of payment and date of service.
- **If you are enrolled in Guardian DGP Plan or another dental plan (other than Guardian MDG)**, you must attach the Explanation of Benefits (EOB) received from the plan **and** receipts showing proof of payment and date of service.
- Entire claim form must be completed in full by the employee or dependent.
- Reimbursements will be made only for services that are covered by Guardian or other dental plan.
- A separate claim form must be submitted per patient.

- All claims must be submitted to our office within <u>one year</u> from the date of service; claims submitted after one year will be denied.

SUPPLEMENTAL MAJOR MEDICAL BENEFIT - $1,000 (PER PERSON)

(INSURED BY HSBP)

HSBP will supplement medical benefits you have received from your primary major medical coverage (your participating employer's plan). This supplemental benefit pays 20% on all payments made by your primary major medical coverage, but not to exceed the Plan Year maximum of $1,000. This 20% supplement will be calculated based on the total reimbursements received under your primary major medical coverage during the Plan Year. You must attach the Explanation of Benefits (EOB) received from your primary major medical coverage along with the receipt showing proof of payment, service(s) rendered, and date(s) of service.

The maximum reimbursement per person per Plan Year is $1,000. In no instance will HSBP reimburse you more than what you are responsible for in out-of-pocket expenses ("patient responsibility"), including copayments and coinsurance and excluding deductibles (see below).

For Example: Your dependent requires a surgery for which the surgeon charges $8,000. Your primary plan's usual and customary charge for this surgery is $8,000, and your primary plan pays $6,400. Assuming your dependent has not used the Supplemental Major Medical Benefit in this Plan Year, you will be paid 20% of the amount reimbursed by the primary major medical coverage up to the annual limit of $1,000. Since 20% of $6,400 is $1,280, you will be paid $1,000, or the annual Supplemental Major Medical Benefit maximum, provided that you paid at least $1,000 out of pocket towards this service.

Example:

Amount of Services Charged to Your Plan	Amount Your Primary Major Medical Coverage Pays	20% of the Primary Major Medical Coverage Payment	Amount You Owe (Coinsurance or Copayment)	Supplemental Reimbursement to You from HSBP
$8,000	$6,400	$1,280	$1,000	$1,000 Maximum Allowed

Under the Supplemental Major Medical Benefit, you may also receive reimbursement for co-pay amounts for office visits, out-patient diagnostic tests (x-rays, lab tests, etc.), emergency room care and hospital admissions. These co-pay amounts will be reimbursed up to 100% with the annual Plan Year maximum of $1,000 per person. The following example shows the procedure for obtaining a reimbursement for a co-pay from the Supplemental Major Medical Benefit.

For Example: Under your primary major medical coverage, the co-pay for an office visit is $15. You obtain a receipt for the office visit for the $15 co-pay because you cannot be reimbursed under the Supplemental Major Medical Benefit without one. You submit the receipt and EOB along with a claim form. Assuming you have not yet met your $1,000 Plan Year maximum, you will be reimbursed $15.

Insurance deductibles paid under your primary major medical coverage are **not** reimbursable under this benefit. Claims must be submitted within one (1) year from the date of service. No benefits will be provided for mental, psychoneurotic and personality disorders under this particular benefit. In no instance will HSBP reimburse you more than what you paid out of pocket.

Smoking Cessation Benefit

Smoking Cessation expenses are covered under the Supplemental Major Medical Benefit reimbursement and subject to the Supplemental Major Medical Benefit maximum reimbursement of $1,000 per person per Plan Year. Acceptable programs include Smoke Enders and programs sponsored by the New York Lung Association. If you are unsure as to whether the service is being rendered by an "Eligible Provider," please contact the Benefits Office. The Smoking Cessation Benefit can also be used to reimburse you for nicotine patches or gum.

How to Make a Claim

You can find the reimbursement claim form on CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- You must attach the Explanation of Benefits (EOB) received from your primary major medical coverage, along with receipts showing proof of payment, service(s) rendered, and date(s) of service; if you don’t have an EOB, please contact your insurance company or provider directly.
- Entire claim form must be completed in full by the employee or dependent.
- A separate claim form must be submitted per patient.
- All claims must be submitted to our office within one year from the date of service.
- Claims submitted after one year will be denied.

SUPPLEMENTAL OUTPATIENT MENTAL HEALTH BENEFIT - $5,000 (PER PERSON)
(INSURED BY HSBP)

HSBP will supplement outpatient mental health benefits you have received from your primary medical coverage (your participating employer's plan). The eligible expenses are charges incurred for the services of an eligible provider in connection with diagnosis and treatment of mental, psychoneurotic and personality disorders. **To be eligible for reimbursement, these services must be rendered on an outpatient basis.** You must attach the Explanation of Benefits (EOB) received from your primary medical coverage along with the receipt showing proof of payment, service(s) rendered, and date(s) of service.

For Dates of Service on or after July 1, 2024

Outpatient mental health benefits will be reimbursed at 80% of out-of-pocket expenses not to exceed $200 per office visit. Therefore, the maximum an employee or dependent may receive per visit is $160: 80% of a $200 office visit is $160.

For Dates of Service before July 1, 2024

Outpatient mental health benefits will be reimbursed at 80% of the reasonable and customary provider charge not to exceed $200 per office visit. For example, the maximum a member may receive is $160: 80% of a $200 office visit is $160.

The maximum benefit per person per Plan Year is $5,000. In no instance will HSBP reimburse you more than what you are responsible for in out-pocket-expenses ("patient responsibility"), including copayments or coinsurance. However, insurance deductibles paid under your primary medical coverage are **not** reimbursable under this benefit. Claims must be submitted within one (1) year from the date of service.

Telehealth mental health benefits are reimbursable under this benefit to the extent that they are covered under your primary medical coverage.

How to Make a Claim

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

You must attach the Explanation of Benefits (EOB) received from your primary medical coverage, along with receipts showing proof of payment, service(s) rendered, and date(s) of service; if you don't have an EOBs, please contact your insurance company or provider directly.

- Entire claim form must be completed in full by the employee or dependent.
- A separate claim form must be submitted per patient.
- All claims must be submitted to our office within one year from the date of service.
- Claims submitted after one year will be denied.

SUBSTANCE USE DISORDER COUNSELING AND TREATMENT BENEFIT
(INSURED BY HSBP)

Part 1: In Hospital Detox and Rehabilitation Benefit

This benefit provides up to a total of 21 days for in-hospital detoxification and up to 28 days for in-patient rehabilitation up to a $10,000 maximum per person per Plan Year. No benefit is payable by HSBP unless you or your dependent(s) have exhausted the benefits provided by you or your spouse's primary coverage, as applicable. In no instance will HSBP reimburse you more than what you are responsible for in out-of-pocket expenses.

Example:

Total Charged for Detox/Rehab	Amount Paid by Primary/Basic Plan	HSBP Pays
$50,000	$37,000	$10,000

To make a claim, contact the Benefits Office for more information. You will be required to submit an Explanation of Benefits (EOB) received from your primary medical coverage, along with receipts showing proof of payment, service(s) rendered, and date(s) of service. In no instance will HSBP reimburse you more than what you are responsible for in out-of-pocket expenses ("patient responsibility"), including copayments and coinsurance and excluding deductibles. Claims must be submitted within one (1) year from the date of service.

<u>Part 2: Substance Use Disorder Behavioral Health Benefit</u>

Outpatient behavioral health coverage for substance use disorder counseling is subject to the rules previously described above under the Supplemental Outpatient Mental Health Benefit. After exhausting the $5,000 Supplemental Outpatient Mental Health Benefit described above, you and any dependent(s) are eligible for an extra $1,500 per person towards substance use disorder behavioral health counseling. However, the total amount reimbursed between these two benefits cannot exceed $6,500 per Plan Year.

To make a claim, contact the Benefits Office for more information. You will be required to submit an Explanation of Benefits (EOB) received from your primary medical coverage, along with receipts showing proof of payment, service(s) rendered, and date(s) of service. In no instance will HSBP reimburse you more than what you are responsible for in out-of-pocket expenses ("patient responsibility"), including copayments and coinsurance and excluding deductibles. Claims must be submitted within one (1) year from the date of service.

<u>Part 3: Urinalysis Monitoring</u>

Benefits are also provided to employees only when certain services are required by the Committee for Physicians' Health of the Medical Society of the State of New York ("CPH") or your employer. A statement from CPH or your employer must be included when submitting for this reimbursement.

Two types of care are available:

Type 1: Aftercare

In cases of substance use disorder (this means the employee was actually admitted in a facility getting treatment and now they are out and need to still have their urine monitored) AFTERCARE will be reimbursed at 80% of out-of-pocket expenses ("patient responsibility"), including copayments and coinsurance and excluding deductibles, up to a maximum of $400 per month for a maximum period of 24 months. *This will be reimbursed only if employee remains on payroll.*

Type 2: Suspicion of Substance Use Disorder

In cases of substance use disorder suspicion (this means that the employee is working and their employer suspects they are under the influence) expenses incurred from urine monitoring will be reimbursed at 100% of out-of-pocket expenses ("patient responsibility"), including copayments and coinsurance and excluding deductibles, up to a maximum of $400 per month for a maximum period of 24 months. *This will be reimbursed only if employee remains on payroll.*

<u>TYPE 1: AFTERCARE</u>

Example 1:

Total charged by provider per month	Percentage Paid	Amount Paid by HSBP
$600	80%	$400

Example 2:

Total charged by provider per month	Percentage Paid	Amount Paid by HSBP
$300	80%	$240

TYPE 2: SUSPICION OF SUBSTANCE USE DISORDER

Example 1:

Total charges by provider per month	Percentage Paid	Amount Paid by HSBP
$600	100%	$400

Example 2:

Total charges by provider per month	Percentage Paid	Amount Paid by HSBP
$200	100%	$200

How to Make a Claim

You can find the reimbursement claim form on the CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- You must attach the Explanation of Benefits (EOB) received from your primary medical coverage, along with receipts; if you don't have Explanation of Benefits (EOB), please contact your insurance company or provider directly. Note that EOBs are not required for the Urinalysis Monitoring benefit.
- A separate claim form must be submitted per patient.
- All claims must be submitted to our office within one year from the date of service.
- Claims submitted after one year will be denied.

SUPPLEMENTAL NEWBORN BENEFITS - $1,000
(INSURED BY HSBP)

This benefit is provided for each newborn delivered while you, your spouse or your domestic partner is covered by this Plan.

The Benefit

HSBP will supplement benefits you have received from your primary medical coverage (under your participating employer's plan). HSBP reimburses up to $1,000 in total per newborn for Newborn Expenses, Well Baby Care, Circumcision and Childbirth Education for yourself and your newborn. This benefit covers expenses for a newborn born to your spouse or domestic partner or a newborn that you have adopted. **You must enroll your newborn as a dependent in HSBP to be eligible for any Supplemental Newborn Benefit.**

You must attach the Explanation of Benefits (EOB) received from your primary medical coverage along with the receipt showing proof of payment, service(s) rendered, and date(s) of service. Insurance deductibles paid under your primary medical coverage are **not** reimbursable under this benefit. However, you do not need to submit an EOB for a claim for reimbursement for the Childbirth Education Benefit.

Claims must be submitted within one (1) year from the date of service. In no instance will HSBP reimburse you more than what you are responsible for in out-of-pocket expenses ("patient responsibility"), including copayments and coinsurance.

Newborn Expenses

HSBP provides coverage for all unreimbursed medical expenses in connection with a newborn for the first sixty (60) days of the child's life (including children who are adopted or born to your spouse or domestic partner).

Well Baby Care

HSBP provides coverage for unreimbursed expenses for a pediatrician's in-hospital newborn baby care.

Circumcision

HSBP will pay for unreimbursed expenses for circumcision by a physician or a certified mohel up to 24 months old.

Childbirth Education Benefit

This benefit enables you to get information and education about childbirth by providing you with up to six (6) group sessions or no more than four (4) private sessions conducted by practitioners who have been accredited with one of the agencies listed:

- ICEA - International Childbirth Education Association
- American Academy of Husband Coached Childbirth Education Association
- ASPO - National Organization for the Lamaze Method
- Childbirth Education Specialist, Inc.

How to Make a Claim

You can find the reimbursement claim form on CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- You must attach the Explanation of Benefits (EOB) received from your primary medical coverage, along with receipts showing proof of payment, service(s) rendered, and date(s) of service; if you

don't have an EOB, please contact your insurance company or provider directly. Note: you do not need to submit an EOB for a claim for reimbursement for the Childbirth Education Benefit.

- Entire claim form must be completed in full by the employee.
- A separate claim form must be submitted per newborn.
- All claims must be submitted to our office within one (1) year from the date of service.
- Claims submitted after one year will be denied.

Summary of Benefit Terms

- You must enroll your newborn as a dependent in HSBP to be eligible for any Supplemental Newborn Benefit.
- HSBP reimburses up to a maximum of $1,000 for the following expenses for the first sixty (60) days of the child's life:
  - **Newborn Expenses** - any unreimbursed ***medical expenses*** in connection with an enrolled dependent newborn (including children who are adopted or born to your spouse or domestic partner)
  - **Well Baby Care -** the pediatrician's unreimbursed in-hospital newborn baby care for enrolled dependent newborn;
  - **Circumcision** – any unreimbursed expenses for services by a physician or a certified mohel for enrolled dependent **up to 24 months old**;
  - **Childbirth Education** - information and education about childbirth provided by accredited practitioners: up to 6 group sessions or 4 private sessions.

SUPPLEMENTAL OBSTETRICAL BENEFIT - $1,000 (PER CHILD)
(INSURED BY HSBP)

HSBP will provide supplemental payment for expenses for obstetrical benefits not reimbursed by your primary medical coverage, including breast pumps, lactation classes and supplies (listed below). The supplemental reimbursement for obstetrical benefits is up to $1,000 per child. You must attach an Explanation of Benefits (EOB) from your primary coverage as well as a receipt showing proof of payment, service(s) rendered, the date(s) of service, and the charge for each service.

Note that private hospital rooms are NOT reimbursed under this benefit. In no instance will HSBP reimburse you more than what you paid out of pocket ("patient responsibility"), including coinsurance and copayments. Insurance deductibles paid under your primary major medical coverage are **not** reimbursable under this benefit.

Breast pumps, breast pump accessories, and lactation classes are payable at 100% under this benefit. You are not required to submit a claim to your primary medical coverage or provide an EOB in order to be reimbursed for these items under this benefit.

Breast pump and breast pump accessories* may be purchased before or after delivery. Claims for obstetrical benefits do not require the newborn to be enrolled as a dependent in HSBP to be reimbursable. **Claims must be submitted within one (1) year of the date of purchase (not date of delivery) and the employee must be on payroll when the expenses are incurred AND at the time of delivery**.

*Eligible breast pump accessories

- Bottles
- Breastmilk storage bags
- Containers
- Breast shields
- Pump bags
- Valves
- Membranes
- Nursing bras and bustiers

Not Reimbursable

- Diapers
- Maternity belts
- Nursing tanks
- Cover-ups
- Nursing pillows

Note: Coverage for a hospital length of stay in connection with childbirth for a mother or her newborn is not restricted by HSBP's payment for supplemental obstetrical benefits. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

How to Make a Claim

You can find the reimbursement claim form on CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- For reimbursement claims for items or services other than breast pumps, breast pump accessories, and lactation classes, you must attach the Explanation of Benefits (EOB) received from your primary medical coverage; if you don't have an EOB, please contact your insurance company directly.
- Entire claim form must be completed in full by the employee.
- Please attach receipt(s) for items and services showing proof of payment, service(s) rendered, the date(s) of service, and the charge for each service and fill out the second page of the claim form listing each item you are requesting reimbursement for.
- All claims must be submitted to our office within one year from the date of service.
- Claims submitted after one year will be denied.
- **Employee must be on participating employer's payroll when the service charges are incurred AND at the time of delivery**.

Summary of Benefit Terms

- HSBP provides supplemental payment for basic obstetrical benefits not fully reimbursed by your primary medical coverage.
- You must enroll your newborn as a dependent in the HSBP to be eligible for any Supplemental Obstetrical Benefit.
- Maximum reimbursement is up to $1,000 per child.
- Breast pumps and breast pump accessories are payable at 100% up to the $1,000 maximum.
- In no instance will HSBP reimburse you more than what you paid out of pocket.

SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT - $750 (PER PERSON)
(INSURED BY HSBP)

PROVIDED THROUGH EXPRESS SCRIPTS INC. (ESI – Group Number JRGA)

This benefit is a supplemental prescription coverage that should be used in conjunction with your participating employer's primary prescription plan. HSBP highly recommends the member enroll in the participating employer's prescription plan for themselves and their family. Whenever possible use your primary prescription plan prior to the supplemental prescription ID card; however, you use this benefit to pay for prescriptions even if you are not enrolled in your participating employer's prescription plan. Please inform the Benefits Office if you are enrolled in your participating employer's prescription plan.

Prescription ID Cards

Employees will be mailed two prescription ID Cards for the employee and any enrolled dependent. You may use the prescription ID cards immediately. Please note: enrolled dependent(s) may not be listed by name on the prescription ID cards.

You can print or download your prescription ID Card from www.express-scripts.com. From the home page, select "Forms & Cards" from the menu under "Benefits," then click on "Print a member ID card" and follow the prompts. To view your virtual prescription ID Card on your smart phone using the free Express Scripts mobile app, tap the menu in the upper-left corner, then tap "Prescription ID Card."

To register for an account or to use the app, you will need your member ID or Social Security Number.

For replacement of a lost card, you may also contact Express Scripts at (800) 467-2006.

Who Is Eligible To Use the Prescription ID Card?

The prescription benefit is **$750 per person per Plan Year.** Employees and their eligible dependents can obtain discounts for prescription drugs at any one of **Express Scripts Inc.** participating providers nationwide. The ID Card is presented to the participating pharmacy for eligibility verification. Once eligibility is established, the cost of the prescription will be reduced by a **discounted** rate. Employee and/or their eligible dependents will not have to pay any cash or make any payment upfront if the balance on the ID Card covers the cost of the prescription.

If your primary prescription plan charges you copayments, you may use this benefit to pay those copayments; please present your ID Card to the participating pharmacy or submit a claim for benefits to Express Scripts. See more information on claims below. You may not use this benefit to cover any deductibles charged by your primary prescription plan.

If you use a non-participating pharmacy to fill your prescription, you will need to submit a claim for benefits to Express Scripts. See more information on claims below.

Do I Throw The ID Card Away After I Exhaust the $750?

After the full balance of the card has been used, the employee and their eligible dependents can continue to use the ID Card to fill prescriptions at a discounted price but will be responsible for any expenses incurred. In the event the ID Card does not have a sufficient balance to pay for the full prescription, the cost of the purchase will be applied to the ID Card and the remaining balance will be the employee's or eligible dependent's responsibility.

This prescription ID Card does not cover any over-the-counter drugs or medications.

To find participating providers, you can logon and register at www.express-scripts.com or call the customer service phone number on the back of your prescription ID card.

The supplemental prescription drug benefit provides up to $750 per Plan Year per person.

What Are Considered Eligible Prescriptions?

Prescription drug expenses eligible for reimbursement are prescriptions which are:

- obtainable only by a physician's written prescription;
- dispensed by a licensed pharmacist; and
- approved by the United States Food and Drug Administration.

For participants enrolled in the NYC PICA Program, you may use this benefit to cover copayments for certain non-specialty injectables that are covered by Express Scripts. Please contact Express Scripts at the customer service phone number on the back of your prescription ID card for more information about covered injectables.

How Do I Find the Balance on My Card?

ESI's customer service representatives can inform you of your ID Card balance; call Express Scripts at (800) 467-2006.

For additional savings on long-term medications, you can use ESI's mail order, home delivery program to get a ninety (90) day supply for the cost of two (2) copayments. Orders and refills are available through the Express Scripts app, by phone, by mail, or your provider can submit the request electronically. You must have a prescription from your provider. For more information about your plan or to transfer a retail prescription to home delivery, visit express-scripts.com or call Express Scripts at (800) 467-2006.

What If I Forgot To Use My Prescription Card and Paid, Used a Non-Participating Pharmacy, or Paid Copayments Under My Primary Prescription Plan?

The reimbursement claim form is available on express-scripts.com, on the cirseiu.org website at https://www.cirseiu.org/wp-content/uploads/2018/01/Claim-Form.pdf.

The reimbursement form asks for information regarding the cardholder, the patient, and the pharmacy. You must complete a separate claim form for each pharmacy used and for each patient. You must submit claims within one year of date of service. You must enclose receipts including the following:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and dosage
- Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)

- Amount paid

For reimbursement, please mail or fax reimbursement claim form and receipts to:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711
Fax: 608-741-5475

Benefits to Assist in Gender Affirming Care

You may elect to use your HSBP benefits for gender affirming care. The benefits provided through the HSBP allow you to receive medical services such as psychological services, hormones and surgery to develop the physical characteristics of your desired gender. **Please note, there is no specific gender affirming care benefit offered through the HSBP; rather, these benefits are already available to you under HSBP for broader purposes.** However, you may use your benefits to assist in gender affirming care.

How To Use Your Current HSBP Supplemental Benefits To Cover Your Gender Affirming Care Expenses:

- Supplemental Outpatient Mental Health Benefit - $5,000 per person per Plan Year
  - The eligible expenses are charges incurred for services in connection with diagnosis and treatment of mental, psychoneurotic and personality disorders. These services must be rendered on an outpatient basis.
  - During the Plan Year, outpatient mental health benefits will be reimbursed at 80% of out-of-pocket expenses not to exceed $200 per office visit.

    Example: the maximum a member may receive is $160: 80% of a $200 office visit is $160. In no instance will HSBP reimburse the member for more than what the member is responsible for in out-of-pocket expenses.
  - The maximum benefit per person per Plan Year is $5,000.
  - Please see more information about the benefit and exclusions in the *Supplemental Outpatient Mental Health Benefit* section of this SPD.

- Supplemental Major Medical Benefit - $1,000 per person per Plan Year
  - HSBP will supplement medical benefits you have received from your primary major medical coverage (your participating employer's plan) up to $1,000 per person per Plan Year. This supplemental benefit pays 20% on all payments made by your primary medical coverage up to the annual maximum.
  - You may also receive reimbursement for co-pay amounts for office visits, out-patient diagnostic tests (x-rays, lab tests, etc.), emergency room care and hospital admissions. This supplemental benefit reimburses up to 100% of the copayments. In no instance will HSBP reimburse you more than what you paid out of pocket ("patient responsibility") or reimburse you for deductibles paid.
  - Please see more information about the benefit and exclusions in the *Supplemental Major Medical Benefit* section of this SPD.

- Supplemental Prescription Reimbursement Benefit - $750 per person per Plan Year
    - This benefit is a supplemental prescription coverage that should be used in conjunction with your participating employer’s primary prescription plan or other prescription drug plan. HSBP highly recommends the employee enroll in the employer’s prescription plan for themselves and their family. Whenever possible use your primary prescription plan prior to the supplemental prescription ID card.
    - Please see more information about this benefit and exclusions in the *Supplemental Prescription Reimbursement Benefit* section of this SPD.

SUPPLEMENTAL SHORT-TERM DISABILITY
(Self-Insured by HSBP)

Introduction

HSBP provides you with partial income replacement during a period of disability due to a non-occupational accident or illness. These benefits will run concurrently with leave taken under the Family and Medical Leave Act (FMLA) and any state statutory disability benefits, when applicable.

Supplemental Short-Term Disability Benefits are available for the employee only. The employee's spouse and other dependents are not eligible for benefits. If you become disabled while on your participating employer's payroll and eligible for benefits under HSBP, Supplemental Short-Term Disability Benefits begin on the eighth (8th) day of a non-occupational disability. Benefits are payable for a maximum of twenty-six (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.

Maximum Amount of the Benefit

- Under this HSBP benefit, the maximum benefit payable is 70% of your weekly salary up to a maximum of $875 per week.
- Your income replacement 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 provided by the state in which you are employed (if applicable) as well as this Supplemental Short-Term Disability Benefit.
- The Supplemental Short-Term Disability Benefit payable by HSBP 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 which you are eligible.

Definition of Disability

"Disabled" means you are unable to work as a result of accidental bodily injuries, sickness, or pregnancy 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. During any period in which you are able to perform any work for remuneration, you will not be considered disabled by HSBP and no benefits will be paid.

Duration of Benefits

Benefits are paid for a maximum of twenty-six (26) weeks of disability during fifty-two (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 twenty-six (26) weeks of disability benefits have been paid.

If your Disability extends beyond twenty-six (26) weeks, you may be eligible for Long-Term 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:

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

If you are eligible for a state-mandated disability benefit, no-fault wage-replacement, or other statutory benefits, you **must** apply for such benefits and provide documentation showing approval of the benefit, the amount of the benefit paid, and the duration of the benefit with your application.

If you are receiving any amounts for paid time off from your employer, you **must** provide documentation showing the amounts with your application.

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 sixty (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 twenty-six (26) weeks from the onset of disability.

How to Make a Claim

To file a claim for this benefit, you must submit a claim form to HSBP.

You can find the Disability Claim form on the CIR website, https://www.cirseiu.org/wp-content/uploads/2021/02/Short-Term-Disability-Claim-Form-Updated.pdf

- If you are eligible for state-mandated disability benefits, obtain a claim form for those benefits from your employer's human resources department and submit it according to instructions.
- You, your physician, and your employer must complete this form.
- If you receive state-mandated disability benefits, no-fault wage replacement, other statutory benefits, or payment for paid time from your employer, you must submit documentation showing approval of the state-mandated or statutory benefit, the amount of the benefit or employer paid time off paid, and the duration of the state-mandated or statutory benefit with your completed claim form.

DISABILITY – LONG TERM GROUP # 348692
(INSURED BY 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. You can review the full terms and conditions of this plan by requesting the Long-Term Disability Plan from the Benefits Office.

Long Term Disability (LTD) Elimination Period (Waiting Period)

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

Gross Monthly Benefit

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 the Certificate of Coverage 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, the maximum period of long-term disability payments will continue based on age at time of disability. For example, if the long-term disability begins at age 60, the maximum period will be five (5) years. Should the long-term disability begin at age 69, the maximum period will be 1 year.

Application for Other Income Required

You must apply for any disability or retirement benefits with which Guardian integrates and which Guardian feels you, your spouse, or dependent child(ren) may be entitled to receive as outlined in the Certificate of Coverage, including commissions, statutory disability benefits, other disability benefits under a group plan, other disability income under a group plan, sick leave, or salary continuation income. 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 that Guardian integrates with, as outlined in the Certificate of Coverage, 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 and Net Monthly Payment 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; € 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 participants 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, and Substance Use Disorder

If you are disabled, as defined by this plan, by a mental or emotional condition or substance use disorder, 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 or substance use disorder, Guardian's payments stop at the earliest of: (a) the date during any one period of disability that you have received sixty (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 sixty (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 fourteen (14) consecutive days, Guardian extends the payments. Guardian extends them until the earliest of: (a) ninety (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 Condition

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 Group Long Term Disability Income 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, 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 twelve (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 forty-five (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; (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 forty-five (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 overinsured by our standards.

To Obtain a Converted 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 forty-five (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 forty-five (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.

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.

REQUIRED DISCLOSURE STATEMENT
For Group Plan No. 348692

This section is a short summary of the benefits this plan provides. These benefits, including any exclusions and limitations, are fully explained in the Guardian Basic Life and Long-Term Disability Certificate of Coverages which should be read along with this Summary Plan Description for a complete description of your long-term disability benefits. Please review your Guardian Basic Life and Long-Term Disability Certificate of Coverage or contact the Benefits Office for more details. This plan provides the following 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.

Filing a Claim for Long-Term Disability Benefits

You must send Guardian written notice of an injury or sickness for which you intend to file a long-term disability claim within thirty (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 (#348692). You will be furnished with claim forms for filing proof of disability within fifteen (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 Guardian within the time set forth below in the section titled *Time Limit for Filing a Long-Term Disability Claim*.

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 Filing a Long-Term Disability Claim

You should file a claim as soon as possible; you should not wait to file a claim until the elimination period has passed. 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 (1) year retroactively from the date the claim is filed.

Continued Proof of Disability – Long-Term Disability

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

Employee Assistance Program

Guardian has arranged to make available an Employee Assistance Program (EAP) for eligible covered persons to receive certain services from third party vendor(s) in addition to the insurance coverage. You can obtain information regarding available services by logging onto www.worklife.uprisehealth.com.

The services described below are not provided by Guardian; Guardian receives no fee from the respective vendor(s) to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendor(s).

These comprehensive EAP services are available for each employee and eligible dependent. If an enrolled employee did not enroll any dependent(s), dependent(s) in their household, including spouse or domestic partners, are still eligible for the EAP. For dependent child(ren), EAP services are only available from ages 7 through 26.

The intent of EAP services is to help with problems of daily living, whether professional or personal. Examples include, but are not limited to:

- Help with child care issues
- Personal issues
- Elderly parent issues
- Stress in the workplace

Services can be for everyday issues, or those related to a crisis. Services may be accessed 24 hours a day, 7 days a week. Services include, but are not limited to, face-to-face counseling of up to 3 visits per issue; unlimited counseling by telephone; access to Work/Life specialists; child and elder care referral; face-to-face consultation with an attorney and discounted services thereafter; financial coaching and planning; employee discounts (see below); and resources for will preparation. Services are provided by Uprise Health.

To access services, contact Uprise Health at (800) 386-7055 or eapcounselor@uprisehealth.com. Services may also be accessed on the Uprise Health website, www.worklife.uprisehealth.com, access code: worklife.

The "Perks at Work" program provides discounts on goods and on-demand classes. To access these services, visit worklife.uprisehealth.com, and use access code "worklife."

All services and products are provided solely by Uprise Health and its contractors, which are unaffiliated to Guardian. Guardian is not responsible for care or advice given by any provider or resource provided under this program. There is no additional charge above the premium HSBP pays Guardian for these services.

When this Long-Term Disability plan ends, access to the EAP services ends for HSBP and for all persons covered under the plan. When HSBP no longer meets the conditions for eligibility for insurance coverage under the Long-Term Disability plan, access to the EAP service ends for HSBP and for all persons covered under the plan. When a covered person's coverage under this Long-Term Disability plan ends, access to the EAP service ends for that person. When a covered person no longer meets the conditions for eligibility for insurance coverage under the Long-Term Disability plan, access to the EAP service ends for the covered person. Guardian reserves the right to terminate, modify or replace any program at any time.

INSMED DISABILITY BENEFITS FOR EMPLOYEES

Selecting Disability Benefits Through InsMed

One of the valuable benefits HSBP provides Employees is a comprehensive disability insurance program that replaces a significant portion of your income and guarantees Employees the right to obtain permanent and portable income and loan repayment disability insurance without any regard to current or pre-existing health conditions.

This portable “own specialty” policy gives all Employees the opportunity to obtain coverage that can supplement the basic disability benefits that you may receive from a future employer, guarantees your right to protect future increases in income and insures your loan obligations. The ability to obtain coverage without having to answer any medical questions is available until sixty (60) days after you complete your training. The main highlights of this program include the ability to apply for:

- Initial benefit from $500 to $7,500 per month of tax-free benefit
- Up to $15,000 of total monthly benefit WITHOUT any health evaluation
- Student Loan Protection of $2,000/month (optional, not available in New York State)
- Business reducing term life insurance of $2,000/month (optional, available in New York State only)
- Catastrophic Rider (optional)
- 3% Cost of Living Rider

Rate Discount for Employees

This coverage is not available to dental residents or to anyone who has previously been denied coverage by any carrier.

A separate “conversion” program with as much as a $5,000 monthly benefit is available to all Employees completing training, regardless of specialty and prior declinations. Under this program, you may “convert” this group term life insurance policy to an individual policy. This policy is only available at graduation and for a limited period of time. Representatives of InsMed are prepared to work with you individually and can help you select the plan designs that best address your protection needs in your new employment. You can reach InsMed at info@insmedinsurance.com or by calling (800) 214-7039.

We hope you take the time to better understand the benefits of your comprehensive long-term disability program and to evaluate how options for portable coverage can provide comprehensive income protection that can be maintained throughout your career.

Your residency or fellowship program has provided you with disability insurance throughout your training. This coverage terminates upon your graduation. You should consider continuing your disability coverage to protect your income.

CONTINUATION OF HSBP BENEFITS WHILE YOU ARE DISABLED
(INSURED BY HSBP)

If you go off your employer's payroll because of disability, you continue to be eligible for up to twelve (12) months coverage for all HSBP benefits so long as you are collecting disability benefits from the Plan for the same time period. Please contact the Benefits Office for more information.

Premiums for COBRA Continuation Coverage

In addition, HSBP will reimburse you up to $1,500 for premiums you pay for COBRA Continuation Coverage of your basic health coverage for twelve (12) months. You must pay the premiums directly and provide proof of payment.

How to Make a Claim

You can find the reimbursement claim form on CIR website, www.cirseiu.org/benefits; select your Employer from the dropdown menu. You may also make a claim through the Member Portal at https://cirmp.novus-360.com/cirmpprod.

- Claim form must be completed in full by the participant.
- You must attach receipts showing proof of payment for the COBRA premiums for continuation of your basic health care coverage.
- All claims must be submitted to our office within one year from the date of purchase of the insurance coverage.
- Claims submitted after one year will be denied.

GROUP TERM LIFE INSURANCE

GROUP #348692

(insured by Guardian Life Insurance)

A death benefit of $150,000 will be paid to any beneficiary you name, if you die from any cause while you are covered under this Plan. If you do not name a beneficiary, this benefit will be paid to your estate. You may name or change your beneficiary at any time.

To Change Your Beneficiary

- You can find the Update Form on the CIR website, www.cirseiu.org/benefits, or on the Member Portal at https://cirmp.novus-360.com/cirmpprod.
- You may change your beneficiary at any time by filing a written notice of the change with the Benefits Office.

Beneficiaries

- If you designate more than one beneficiary and fail to specify each beneficiary's share, each beneficiary will receive equal shares.
- If your beneficiary dies before you do, his or her share will be shared equally by any beneficiaries that survive you, unless you indicate otherwise. If all your beneficiaries die before you do, or your life insurance benefit amount cannot otherwise be disposed of, the amount will be payable to your estate, spouse, parent(s), child(ren), or sibling(s), unless you made a gift assignment.

Are There Different Forms of Payments?

- All payments will be processed at Guardian Life Insurance Company.
- There are two options that beneficiaries can choose from: a lump-sum option, and the "Guardian Asset Account" option, which is set up like a bank account.

How to Make a Claim

Instructions and the Life Insurance claim form can be found at https://www.cirseiu.org/wp-content/uploads/2018/03/GG42-2017.pdf.

At the time of death, if the beneficiary does not live in the U.S., the beneficiary will need to complete an IRS Form W-8 or W-9.

Claims must be submitted to Guardian at www.GuardianAnytime.com, by clicking on "Secure Channel" on the home page, or by mail or fax at:

Group Life Claims
P.O. Box 14334
Lexington, KY 40512
Fax: (610) 807-8266

Customer Service: (800) 525-4542

Group Term Life Insurance During Total Disability

If you are eligible for benefits under HSBP and you become disabled before you reach age 60, your Term Life Insurance may be continued at no cost to you while you remain totally disabled. This benefit is also called the Extended Life Benefit with Waiver of Premium. You may make a claim during the nine (9) month waiting period, but you must file a claim within one (1) year of the onset of total disability. You must also furnish proof of total disability within one year of the date total disability starts, and as required thereafter.

If you die during the first year of total disability, your death benefit will be paid to your beneficiary even if you had not yet furnished proof of the disability.

For the purpose of this section only, “total disability” or “totally disabled” means, due to sickness or injury:

- You are not engaged in any gainful occupation;
- You are not able to perform any work for wages or profit;
- You are receiving regular doctor’s care appropriate to the cause of the disability; unless you have reached your maximum point of recovery yet are still disabled under the terms of the Plan; and
- You remain totally disabled for nine consecutive months; however, you may apply for this benefit immediately upon the onset of disability.

In the event that you receive the Extended Life Benefit with Waiver of Premium nine (9) months after you become disabled, in order for you to maintain your Dependent Life Insurance coverage, you must convert your spouse’s policy to an individual permanent or term policy.

How to Make a Claim

Complete the Application for Waiver of Group Life Insurance Premium claim form and submit to Guardian at www.GuardianAnytime.com by clicking on “Secure Channel” on the home page, or mail or fax to:

Guardian Group Life Claims
PO Box 14334
Lexington, KY 40512
Fax: (610) 807-8270

Customer Service: (800) 525-4542

Accelerated Life Benefit

IMPORTANT NOTICE: Use of the benefit provided in this section may have tax implications and may affect government benefits or creditors. You should consult with your tax or financial advisor before applying for this benefit.

NOTE: The amount of group term insurance is permanently reduced by the amount of the accelerated benefit paid to you.

An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die. If you have a medical condition that is expected to result in your death within six (6) months, you may apply for the Accelerated Life Benefit. A claim must be made prior to your death, and you must provide documentation that you are expected to die within six (6) months with your claim. The minimum amount of the Accelerated Life Benefit for which you can apply is $50,000; the maximum amount of the Accelerated Life Benefit for which you can apply is $75,000. This benefit is payable one time only.

Guardian will not pay an Accelerated Life Benefit to you if you are required by law to use the payment to meet the claims of creditors whether or not you are in bankruptcy; or are required by court order to pay all or part of the benefit to another person; or are required by a government agency to use the benefit to apply for, to receive or to maintain a governmental benefit or entitlement; or lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before Guardian pays such benefit to you.

Burial Benefit: At its option, Guardian Life Insurance may pay up to $500 of the life insurance benefit to any person who appears to have incurred an expense in connection with your burial. Guardian’s liability will be discharged to the extent of the amount paid.

How to Make a Claim

Complete the Accelerated Group Life Benefit Application claim form and Group Term Accelerated Life Benefit Summary and Disclosure Statement form and submit to Guardian at www.GuardianAnytime.com by clicking on "Secure Channel" on the home page, or mail or fax to:

Guardian Group Life Claims
PO Box 14334
Lexington, KY 40512
Fax: (610) 807-8270

Customer Service: (800) 268-2525

Conversion to an Individual Policy

During the first thirty-one (31) days following:

- the termination of your employment; or
- the group policy providing your Group Term Life Insurance ends; or
- the amount of your insurance is reduced by amendment

You may convert your Group Term Life Insurance to one of a number of Guardian individual life insurance policies up to the amount of the coverage you lost. You must apply in writing for a conversion policy and pay the first premium within thirty-one (31) days after your insurance ends or is reduced. You will not have to furnish evidence of good health. The policy will be effective at the end of the thirty-one-day period, and the premiums will be based on current individual policy premium rates. If you die during the thirty-one (31) day period, your death benefit will be paid whether or not you have applied for an individual policy. **By law, you are responsible for paying taxes on the value of your life insurance above $50,000. You will be notified of the amount by your participating employer.**

For more information on conversion, and an explanation of the difference between porting and converting your life insurance, please visit https://www.cirseiu.org/wp-content/uploads/2021/06/Portability-vs-Conversion_11.2.pdf.

How to Make a Claim

Mail, fax, or email the claim form to:

Guardian
National Conversion Department
PO Box 8070
Appleton, WI 54912-8070
Fax: (920) 749-6219
Secure email: national_conversions@glic.com

LIFE TERM INSURANCE FOR YOUR SPOUSE OR DOMESTIC PARTNER
(INSURED BY GUARDIAN LIFE INSURANCE)

A death benefit of $20,000 will be paid to you if your legal spouse or domestic partner, as recognized and allowed by federal or state law, dies from any cause while covered by HSBP.

Conversion to an Individual Policy

During the first thirty-one (31) days following:

- the Term Life Insurance for your Dependent Spouse ends, or
- the amount of the Term Life Insurance for your Dependent Spouse is reduced by amendment; your spouse may convert such life insurance to one of a number of Guardian individual life insurance policies up to the amount of coverage lost without the need to furnish evidence of good health. Your spouse must apply in writing for a conversion policy and pay the first premium within thirty-one (31) days after his/her insurance ends or is reduced. The policy will be effective at the end of the thirty-one-day period, and the premiums will be based on current individual policy premium rates. If your spouse dies during the thirty-one-day period, this death benefit will be paid whether or not your spouse has applied for an individual policy.

In the event that you, the employee, become totally and permanently disabled and you apply for and receive the Extended Life Benefit with Waiver of Premium, life insurance for your spouse will terminate. In order to maintain your spouse's coverage, you must convert the coverage to an individual policy.

If your dependent is confined for medical care or treatment either in an institution or at home on the date this dependent life insurance would otherwise go in effect, or on the date any adjustment to the benefit amount would become effective, then your dependent's insurance will be deferred until his/her final release from medical confinement.

How to Make a Claim

Claims must be submitted to Guardian at www.GuardianAnytime.com, by clicking on "Secure Channel" on the home page, or by mail or fax at:

Group Life Claims
P.O. Box 14334
Lexington, KY 40512
Fax: (610) 807-8266

Customer Service: (800) 525-4542

ANCILLARY DEATH BENEFIT
(INSURED BY HSBP)

This benefit assists in the payment for transporting the remains of a deceased employee or deceased eligible dependent to the place of burial. The benefit will cover up to a maximum of $5,000 for transportation of the remains of the deceased to the place of burial where the place of burial is more than two hundred (200) miles from New York City.

Eligibility:

You are eligible for this benefit if you are a New York City Health + Hospitals employee.

How to Make a Claim

At the time notification of the death is made to the Benefits Office, the Benefits Representative will assist the caller with this benefit.

ACCIDENTAL DISMEMBERMENT BENEFIT
(INSURED BY HSBP)

This employee-only benefit will be paid for any of the following losses as the result of an accident occurring on or off the job to the employee while the employee is insured. The injury must have resulted in the loss directly and independently of all other causes, and the loss must have occurred within ninety (90) days after the injury was sustained. It is payable in addition to any other insurance for which you may be eligible.

All benefits are payable to the employee, except that any benefit unpaid at your death will be paid to your beneficiary or beneficiaries.

For Loss of:	Full Amount of Insurance
Both hands, Both feet, Sight of both eyes, One hand and one foot, One hand and sight of one eye, or One foot and sight of one eye	Which is $50,000 paid to you
For Loss of:	One-Half of the Amount of Insurance
One hand, One foot, or Sight of one eye	Which is $25,000 paid to you

- Loss of sight means total and irrevocable loss of sight. Loss of a hand or foot means loss by severance at or above the wrist or ankle.
- The total payment for all losses due to any one accident will not be more than the full amount of the benefit.

Exclusions

The Accidental Dismemberment Benefit does not cover:

- any loss resulting from war or any act of war (including undeclared war and resistance to armed aggression);
- attempted suicide;
- any loss which results directly or indirectly from bodily or mental infirmity or disease or medical or surgical treatment for such;
- any loss which results from an infection other than a pyogenic infection of an accidental cut or wound;
- any loss which results from travel in any moving aircraft aboard which you are giving or receiving training or have any duties.

How to Make a Claim

Please contact the Benefits Office to make a claim for the Accidental Dismemberment Benefit.

CLAIMS INFORMATION

How to make a claim for HSBP Benefits

1. Make sure your enrollment form is on file with up-to-date information.
2. Follow the "How to Make a Claim" instructions contained in each section above to access the relevant claim form and for specific details about making a claim for a particular benefit.
3. When completing a claim form, be sure to complete every section.
4. Complete a separate claim form for each employee and dependent.
5. Provide all the information requested on the claim form and enclose all requested documents.
6. Keep copies of all documents sent to the Benefits Office.

Note: if you receive services from a provider in the Guardian Managed DentalGuard network, or if you receive Vision Benefit services from a provider in the Davis Vision network, you do not have to submit a claim form. Your provider will file the claim on your behalf.

If you need a copy of a claim form, contact the Benefits Office at (212) 356-8180 or benefits@cirbenefitfunds.org.

Time to File Claims

There is a one-year limit beginning on the date of service to file a claim for benefits, with limited exceptions listed immediately below. If your claim is not filed within the applicable period of time, no benefit will be paid.

- You must file a claim for a Long-Term Disability Benefit no later than a reasonable period of time following the end of the Elimination Period for such claim. However, you should file a claim as soon as possible; you should not wait to file a claim until the Elimination Period has passed.

- Specific limits may apply to dental benefit claims.

Please see the sections discussing these benefits for more information.

Policies and Certificates Insurance Contacts Govern

This Summary Plan Description describes the principal features of HSBP. The complete terms of the Insured coverage are set forth in the insurance policies issued by the insurance carriers for benefits which are not self-insured by HSBP. Individual certificates of insurance are available to you upon request. The Benefits Office will give or mail to you a copy of the policy if you call or mail your request. In the event of any question regarding the interpretation of these certificates or the proper payment of benefits, you can obtain information from the Benefits Office. If there is any inconsistency between this Summary Plan Description and the insurance contracts, the insurance contracts will govern.

CLAIMS REVIEW AND APPEAL PROCEDURE

If your claim is denied in whole or in part, HSBP will notify you in writing with reference to the plan provisions on which the denial was based within ninety (90) days of the date you submitted your claim. When applicable, you will be told what additional information is required from you and why it is needed. You will then be entitled, upon written request, to a review of that claim decision or adverse benefit determination. This section describes the procedures followed by the Plan in determining requests for review of disputed claims.

For purposes of this Claims Review and Appeal Procedure, “adverse benefit determination” means a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual’s eligibility to participate in the Plan or a determination that a benefit is not a covered benefit and includes a Rescission of Coverage, whether or not there is an adverse effect on any particular benefit.

A. <u>Request for Review of Disputed Claims</u>

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a request for review of the disposition of your claim or adverse benefit determination regarding your claim:

- *Requests for review of Guardian Long-Term Disability claims must be made within 180 days of Guardian’s adverse benefit determination (see below).*
- *Requests for review of Guardian Dental claims must be made within sixty (60) days of Guardian’s adverse benefit determination (see below).*
- *Requests for review of Guardian Life Insurance claims must be made within sixty (60) days of Guardian’s adverse benefit determination (see below).*
- *For request for review of Davis Vision claims, see below.*

For requests for review of all other benefits*, your request for review must be made in writing within 180 days of written notice of the Plan’s adverse benefit determination. Mail your request for review to the Board of Trustees of HSBP at 10-27 46th Avenue, Suite 300-2, Long Island City, New York 11101, or email your appeal to benefits@cirbenefitfunds.org.*

You will be notified, in writing, of the decision of the Board of Trustees within sixty (60) days (forty-five (45) days for disability claims) of the date your request for review is received, unless there are special circumstances, in which case you will be so notified and then notified of the decision within 120 days (ninety (90) days for disability claims). The decision will include the specific reason(s) for the decision and specific reference(s) to the plan provisions on which the decision is based.

Requests for Review of Guardian Long-Term Disability Claims (Group #348692)

Requests for review must be made within 180 days of Guardian’s adverse benefit determination.

Mail claims to:

The Guardian Life Insurance Company of America
Attention: Appeals Department
PO Box 14333
Lexington, KY 40512

Guardian will notify you of its decision within forty-five (45) days of your written request for review. If special circumstances require an extension of time for a decision on review, the review period may be extended by an additional forty-five (45) days (or ninety (90) days in total). Guardian will notify you in writing if an additional 45-day extension is needed. If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the

45-day extension of the appeal period will begin after you have provided the information. If you fail to deliver the requested information within the time specified, Guardian may decide your appeal without that information.

Requests for Review of Guardian Dental Claims (Group #417732)

Requests for review must be made within sixty (60) days of Guardian's adverse benefit determination.

If your claim is a Guardian ManagedDentalGuard claim, call Guardian Member Services at (888) 618-2016 to request review of your claim within 180 days of Guardian's adverse benefit determination.

If your claim is a Guardian DentalGuard Preferred claim, call Guardian Member Services at (800) 541-7846 to request review of your claim within 180 days of Guardian's adverse benefit determination.

You can also mail your complaint, grievance or appeal to:

Guardian
Attention: Appeals Department
PO Box 2457
Spokane, WA 99210-2457

Requests for Review of Guardian Life Insurance Claims (Group #348692)

Requests for review of must be made within sixty (60) days of Guardian's adverse benefit determination.

Mail claims to:

The Guardian Life Insurance Company of America
Attention: Appeals Department
PO Box 14334
Lexington, KY 40512

If your claim is a Guardian Life Insurance claim, your request for review must be made within sixty (60) days of Guardian's adverse benefit decision. Guardian will notify you of its decision not later than sixty (60) days after receipt of the request for review of the adverse benefit determination. This period may be extended by an additional period of up to sixty (60) days (120 days in total) if Guardian determines that special circumstances require an extension of the time period for processing and so notifies you before the end of the initial 60-day period. Guardian will notify you in writing if an additional sixty (60) day extension is needed. If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least sixty (60) days from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the sixty (60) day extension of the appeal period will begin after you have provided the information. If you fail to deliver the requested information within the time specified, Guardian may decide your appeal without that information.

If your claim is a Guardian Waiver of Premium claim, your request for review must be made within 180 days of Guardian's adverse benefit decision. Guardian will notify you of its decision not later than forty-five (45) days after receipt of the request for review of the adverse benefit determination. This period may be extended by an additional period of up to forty-five (45) days (or ninety (90) days in total) if Guardian determines that special circumstances require an extension of the time period for processing and so notifies you before the end of the initial 45-day period. If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after you have provided the information. If you fail to deliver the requested information within the time specified, Guardian may decide your appeal without that information.

Requests for Review of Davis Vision Claims (Client Code 2200)

Appeals for vision benefits must 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 (888) 343-3470 or mail your complaint, grievance or appeal to:

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

In all communications about a claim, be sure to include your identification number and group number.

B. Discretionary Authority of the Trustees and their Designees

HSBP of the Committee of Interns and Residents (CIR) is an employee benefit trust fund, financed by contributions fixed by collective bargaining or other written agreements, and administered by a Board of Trustees, all of whom are appointed by the CIR President and approved by the CIR Executive Board, pursuant to an Agreement and Declaration of Trust, 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 a Plan of benefits set forth and described by the Summary Plan Description (SPD). Under the Trust Agreement and SPD, the Trustees may, in 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 of interpretation, construction, application or enforcement of the terms of the HSBP and this SPD, and all determinations on benefit claims and appeals and determinations of eligibility and entitlement to benefits, are subject to the discretion of the Board of Trustees and other Plan fiduciaries and individuals to whom responsibility of the administration of the Plan has been delegated, whose interpretations and determinations are final and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

C. Additional Information

If additional information is needed, it will be requested by HSBP or the appropriate carrier. Failure to timely provide the information may require the denial of the claim or appeal.

D. Finality

In deciding claims, the Board of Trustees has broad discretion to interpret and apply the terms of this HSBP and Summary Plan Description.

The determination of the HSBP will be final and binding if an objection or request for review is not filed in a timely manner. The decision of the Board of Trustees will be final and binding on any timely appeal presented to it.

E. When a Lawsuit May Be Started

No lawsuit shall be brought to recover benefits under HSBP unless you have exhausted the appeals procedure outlined above. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the time limit(s) set forth in Section A, above, have elapsed since you filed a request for review and you have not received a final decision or notice that additional time will be necessary for the Trustees to reach a final decision. Any lawsuit must be filed within three (3) years from the date of the final decision of the Trustees.

Special rules may apply to certain dental benefits; call the Benefits Office for information.

F. Notification and Right to Commentary and Information

Upon any adverse benefit determination, HSBP will notify the Claimant of this Claims Review and Appeal Procedure and its time limits. A Claimant may review pertinent documents and submit written issues and comments, records or other information relating to the claim. A Claimant shall be provided upon request

and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. All comments, documents, records, and other information submitted by the Claimant will be taken into account at any stage of the Claims Review and Appeals Procedure and process. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, such will be stated and a copy will be provided upon request. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request. The HSBP will provide for the identification of medical or vocational experts whose advice was relied on in connection with an adverse benefit determination.

G. Medical Judgments

In deciding any appeal based in whole or in part on a medical judgment, the Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the adverse benefit determination nor the subordinate of any such individual.

COORDINATION OF BENEFITS
(Guardian Dental Benefits Only)

Important Notice
This section applies to dental benefits, which are insured by Guardian. These terms are fully explained in the Guardian Certificate of Coverage.

Purpose
When a covered person has health care coverage under more than one plan, this section allows this dental plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense
This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

- If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim
This term means a request that benefits of a plan be provided or paid.

Claim Determination Period
This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination of Benefits
This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent
This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan
This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice, and individual practice plans. This term also does not include: (i) blanket school accident type coverage or such coverage issued to a substantially similar group; or (ii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description. Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan
This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan
This term means a plan that is not a primary plan.

This Plan
This term means the group health benefits, except prescription drug coverage, if any, provided under this Guardian group plan.

Order of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

Order in which HSBP will Coordinate:

1. The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

2. The plan that covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan that covers the person as a dependent of a person whose birthday comes later in that calendar year.

3. If items 1 and 2 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed primary and will pay its benefits first, except that the benefits of a plan which covers the person as a retired employee or the dependent of such person shall be determined after the benefits (that is, as a secondary plan) of any other plan which covers such person as an employee who is not retired or a dependent of such person. If either plan does not have a provision regarding retired employees and as a result each plan determines its benefits after the other, then the preceding sentence will not apply.

Coordination of Benefits with Medicare
If you or your spouse is age 65 or older, you are eligible for Medicare even if you are not retired. Medicare includes hospital insurance benefits (Part A), other medical insurance (Part B), and prescription drug benefits (Part D).

As stated above, the plan that covers the person other than as a dependent (for example, as an employee or member) is primary and the plan that covers the person as a dependent is secondary. However, if a person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent

and primary to the plan that covers the person other than as a dependent (for example, a retiree), then the order of payment between the two plans is reversed so that the plan that covers the person as an employee or member, etc., is secondary and the other plan covering the person as a dependent is primary. Note that special rules apply if you or your dependent are entitled to Medicare because of End Stage Renal Disease or disability. Contact the Benefits Office at (212) 356-8180 for more information.

Child Covered under more than One Plan
The order of benefit determination when a child is covered by more than one plan is:

1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active or Inactive Employee
The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage
The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length of Coverage
The plan that covered the person longer is primary.

Other
If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But this plan will not pay more than it would have had it been the primary plan.

Effect on the Benefits of this Plan

When This Plan Is Primary
When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations

or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Policies and Certificates

This document describes the principal features of HSBP. The complete terms of the insured coverage are set forth in the insurance policies for benefits that are not self-insured by HSBP. Individual certificates of insurance are available to you upon request. The Benefits Office will give or mail to you a copy of the policy if you call in or mail your request. In the event of any questions regarding the interpretation of these certificates or the proper payment of benefits, you can obtain information from the Benefits Office.

Liens, Lawsuits, and Other Compensable Sources

If you should suffer an illness or injury, or require medical treatment through the act or omission of someone else or for which a third party may be legally responsible, for which benefits under HSBP's coverage is payable, the following subrogation provisions will apply. If this illness or injury is the result of an accident for which payment may be available from another source, a claim may be submitted for these expenses and payment considered by the Trustees. It is possible that the HSBP may advance benefit payment in order to assist you in your time of need. HSBP will have the right to recover any paid benefits from the responsible party. In addition, HSBP will have the right to recover any payments which were made to a covered individual and which caused a duplicate payment for the same expenses. The covered individual will cooperate with and assist HSBP in recovering any benefits for which other payment is available. The covered individual must reimburse HSBP promptly out of any recovery from any source, including the third party or the third party's insurer, for the benefits paid to the covered individual. HSBP's right to subrogation and reimbursement applies to all rights of recovery of the covered individual and the covered individual's dependents, parents, representative, guardian or trustee, regardless of whether the recovery fully compensates the covered individual for the loss. Acceptance of benefits from HSBP automatically assigns to HSBP any rights to recovery of duplicate payments. HSBP has a constructive trust and an equitable right to and lien with regard to any monies received by an employee or dependent and/or his or her attorney or representative from a third party to the extent of benefits as described above. You must forward any recovery to HSBP within ten (10) days of receipt or notify HSBP why you are unable to do so.

HSBP must be reimbursed in full up to the total amount of all benefits paid by HSBP in connection with the injury or illness from any recovery you receive from a third party, as well any first-party coverage, including, but not limited to, any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, school insurance or workers' compensation insurance, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party or first-party coverage (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse HSBP for benefits paid. In the event you receive an award for future medical expenses, HSBP will not pay any benefits until you demonstrate that the full award of future medical benefits has been used to treat the injury or illness. The HSBP has the right of first reimbursement on a priority first-dollar basis out of any recovery obtained, even if you are not fully compensated (or "made whole") for your loss, and HSBP's claim has first priority over all other claims and rights.

Neither you nor your dependent is compelled to pursue any right of recovery from a third party whose conduct caused the injuries for which benefits were paid by HSBP. The Trustees strongly recommend, however, that if you are injured as a result of the negligence or wrongful act of a third party, you should contact an attorney for advice and counsel. HSBP cannot and does not pay for the legal fees your attorney may charge.

You are required to notify HSBP promptly of any third-party claim you may have for an injury or illness for which the HSBP has paid or may pay benefits and any demand made or suit filed against any third party. You are required to notify the HSBP of any third-party recovery, whether in or out of court, that you, your dependent, or your parents or any agent, representative or trustee or any of them obtains.

HSBP's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of HSBP's claim is subject to prior written approval by the Trustees in their sole discretion.

If you choose not to pursue the liability of a third party, HSBP will be subrogated to your right of recovery and may pursue your claims against the third party. You agree to cooperate with HSBP with respect to any attempt to recover HSBP benefits payable to you or your eligible dependent related to an injury or illness caused by the act or omission of a third party.

Note that other provisions of HSBP may exclude or limit coverage under certain circumstances where the injury or illness may have been the result of the act or omission of a third party (e.g., Workers' Compensation cases, certain automobile accidents, etc.). Please review carefully the specific limitations and exclusions.

NOTICE OF ELECTRONIC DISCLOSURE

Use of electronic notices by HSBP.

HSBP may, at times, send Notices by e-mail to HSBP 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 Summary Plan Descriptions (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. HSBP may at times also send communications via first class mail.

HSBP's use of electronic notices is governed by the following terms and conditions:

Privacy: By law, HSBP cannot use your information without your permission, except as described in our Notice of Privacy Practices located in this SPD.

Contact Information: You are responsible for ensuring HSBP 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 HSBP in writing or by sending an email to benefits@cirbenefitfunds.org. Any communication sent by HSBP 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 HSBP in writing or by sending an email to benefits@cirbenefitfunds.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 https://get.adobe.com/reader/.

Risks: HSBP 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. HSBP is not responsible for any such event.

HOUSE STAFF BENEFITS PLAN ADDITIONAL PLAN INFORMATION

1. The House Staff Benefits Plan of the Committee of Interns and Residents (CIR) 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 Benefits Office, and their address for HSBP business is:

   House Staff Benefits Plan
   10-27 46th Ave, Suite 300-2
   Long Island City, NY 11101

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 Benefits Office is:

   House Staff Benefits Plan
   10-27 46th Ave, Suite 300-2
   Long Island City, NY 11101

   Lorenzo Gonzalez, Chairperson, MD, MPL
   Harbor UCLA
   1000 W Carson, Torrance, CA 90502

   Yariana Rodriguez Ortiz, MD
   Wyckoff Heights Medical Center
   374 Stockholm Street, Brooklyn, NY 11237

   Michael Zingman, MD, MPH
   Bellevue Hospital
   462 First Avenue, New York, NY 10016

   Fan Jim Yang, MD
   Jacobi Medical Center
   1400 Pelham Parkway South, Bronx, NY 10461

The telephone number is (212) 356-8180. The fax number is (212) 356-8181. You may send e-mail to benefits@cirbenefitfunds.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 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 an HSBP Trustee.

4. Public employers make contributions to HSBP in accordance with Collective Bargaining Agreements between the Committee of Interns and Residents and themselves. The Collective Bargaining Agreements require contributions to HSBP at fixed rates per year per employee. Presently the New York City Health + Hospital (NYC H+H) is one of the participating employers.

5. Benefits are provided from HSBP'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. HSBP's assets and reserves are managed by Stacey Braun Associates, Inc., 377 Broadway, New York, New York 10013. HSBP's assets and reserves are invested in equities, federal government securities and investment-grade fixed income securities.

7. HSBP'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 of this SPD.

8. All of the types of benefits provided by HSBP are set forth in the Schedule of Benefits grid on page iii of this SPD. The complete terms of the life and dental 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 dependents may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a participating employer in HSBP and, if so, the participating employer's address. Employees and dependents may receive from the Plan Administrator, upon written request, a complete list of the employers participating the HSBP. The HSBP is maintained pursuant to Collective Bargaining Agreements. A copy of any such Agreement may be obtained by employees and dependents upon written request to the Plan Administrator, and is available for examination by employees and dependents.

10. HSBP is an employee welfare benefit plan and some components are group health plans.

COBRA GENERAL (INITIAL) NOTICE

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

Entitlement to COBRA Continuation Coverage: In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under HSBP when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). This notice explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect your rights to obtain coverage.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this section is intended to expand a person's COBRA rights.

COBRA Plan Administrator: The Benefits Office, located at 10-27 46th Ave, Suite 300-2, Long Island City, NY 11101, Phone: (212) 356-8180, Fax: (212) 356-8181, benefits@cirbenefitfunds.org, is responsible for the administration of COBRA, and the organization to which you can direct questions about COBRA.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long?

Each Qualified Beneficiary as described below has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees and the spouse of a covered employee who is a Qualified Beneficiary may elect COBRA on behalf of all other Qualified Beneficiaries and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under HSBP as other covered individuals including Special Enrollment and Open Enrollment.

"**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Employee (or former Employee) or the Spouse (or former spouse) or dependent child of an employee who is covered by HSBP when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who is losing coverage under HSBP because he or she is no longer a dependent under HSBP is a Qualified Beneficiary. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered employee, who is receiving benefits under HSBP because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new Spouse of an existing COBRA employee during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA employee but is not a "Qualified Beneficiary." This means that if the existing COBRA employee dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

NOTE: Domestic Partners and child(ren) of Domestic Partners are NOT offered the ability to elect COBRA Continuation Coverage because Domestic Partners and child(ren) of Domestic Partners are not considered Qualified Beneficiaries. Upon termination of coverage, a Domestic Partner and his/her child(ren) who are not Dependents of the Employee will only be entitled to continue coverage under federal COBRA if the Domestic Partner and his/her child(ren) were enrolled in the Plan the day before the Qualifying Event and the Employee elects to continue coverage for him/herself and elects to continue coverage for the Domestic Partner and his/her child(ren).

"Qualifying Event": Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of

the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under HSBP. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under HSBP (*e.g.*, the employee continues working even though entitled to Medicare), then COBRA is not available.

The following chart lists the COBRA Qualifying Events, Qualified Beneficiaries, and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Maximum* Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	Up to 36 months	Up to 36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent child ceases to have dependent status.	N/A	N/A	36 months

**The maximum period of COBRA Continuation Coverage may be cut short, as explained in the section titled "Early Termination of COBRA Continuation Coverage."*

[1] When a covered employee's Qualifying Event occurs within the eighteen-month period after the Employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA Coverage for a maximum period that ends thirty-six (36) months after the date the Employee became eligible for Medicare.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either eighteen (18) months or thirty-six (36) months, depending on the Qualifying Event that occurred, and is measured from the date the Qualifying Event occurs. The eighteen (18) month period of COBRA Continuation Coverage may be extended for up to eleven (11) months under certain circumstances (see section on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this section.

Medicare Enrollment and COBRA Continuation Coverage

If a person does not enroll in Medicare Part A or B when they are first eligible after the Medicare initial enrollment period, there is an eight (8) month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after employment ends; or
- The month after group health plan coverage based on current employment ends.

If a person does not enroll in Medicare and elects COBRA Continuation Coverage instead, he or she may have to pay a Part B late enrollment penalty and he or she may have a gap in coverage upon deciding to enroll in Part B. If a person elects COBRA Continuation Coverage and later enrolls in Medicare Part A or B before the COBRA

[1] See https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease.

Continuation Coverage ends, HSBP may terminate the COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the person enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If a person is enrolled in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second.

For more information about eligibility and enrollment, visit https://medicare.gov/medicare-and-you.

ALTERNATIVES TO COBRA CONTINUATION COVERAGE

You, your spouse, and dependent children may have other coverage options through the Health Insurance Marketplace, Medicaid, the Children's Health Insurance Program, and/or other options (such as a spouse's plan) through what is called "special enrollment period." Some of these options may cost less. The time limits for enrollment may vary. You can learn more about many of these options, and the time limits for enrollment, at www.healthcare.gov. You have sixty (60) days from the loss of coverage to enroll in the Health Insurance Marketplace. After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away. The special enrollment right may also be available to you, your spouse, and dependent children if you continue COBRA for the maximum time available to you. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

Note that if you sign up for the Marketplace coverage instead of COBRA Continuation Coverage, you cannot switch to COBRA Continuation Coverage once your election period ends. If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. If you terminate your COBRA Continuation Coverage early without another Qualifying Event, you may have to wait to enroll in Marketplace coverage until the next open enrollment period.

Enrolling in another group health plan

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Procedure for Notifying the Plan of a Qualifying Event

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under HSBP, you and/or a family member must inform HSBP in writing of that event sixty (60) days **from the later of the date the Qualifying Event occurs or the date on which the Qualified Beneficiary loses (or would lose) coverage under HSBP as a result of the Qualifying Event.**

That written notice should be sent to the Benefits Office. The written notice can be sent via first class mail, be hand-delivered, faxed, or emailed, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

> **NOTE: If notice of a Qualifying Event is not received by the Benefits Office within the sixty-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.**

The employee's own participating employer should notify the Benefits Office of an employee's death, termination of employment, reduction in hours, employer bankruptcy, or covered employee becoming entitled to Medicare. However, **you or your family should also promptly notify the Benefits Office in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

The Benefits Office will give you and/or spouse and covered dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage ("election notice") within fourteen (14) days of when:

a. **your participating employer notifies HSBP** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under HSBP, you died, you became entitled to Medicare, the employer's bankruptcy, or

b. **<u>you</u> notify the Benefits Office** if a dependent child lost dependent status, you divorced or have become legally separated. <u>Failure to notify HSBP in a timely fashion may jeopardize an individual's rights to COBRA coverage</u>.

Under federal law, you and/or your covered Dependents will then have sixty (60) days from the later of the date of the election notice from the Benefits Office or the date on which you lose (or would lose) your coverage as a result of the Qualifying Event to decide whether you want to elect COBRA Continuation Coverage.

Electing COBRA Continuation Coverage

To elect COBRA Continuation Coverage, you must complete the election form. This form must be received by the Benefits Office or postmarked on or before the date on the form, which is sixty (60) days from the later of the date of the form or the date on which you lose (or would lose) your coverage as a result of your Qualifying Event. Each Qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, the employee's spouse may elect coverage even if the employee does not. The spouse of an employee who is a Qualified Beneficiary may elect coverage on behalf of all other Qualified Beneficiaries.

NOTE: If you, your spouse and/or any of your covered dependents do not elect COBRA Continuation Coverage within sixty (60) days from the later of the date of the election notice or the date on which you lose (or would lose) your coverage, you and/or they will have no group health coverage from HSBP after the date on which you lose coverage as a result of the Qualifying Event.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under HSBP to end, but you must pay for it. See the section below, *Paying for COBRA Continuation Coverage*, for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by HSBP to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Note that HSBP's COBRA Continuation Coverage does not include the Life Insurance, Accidental Dismemberment, Supplemental Short-Term Disability, or Long-Term Disability Benefits. COBRA Continuation Coverage is only applicable for health benefits.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. HSBP is permitted to charge the full cost of coverage for similarly situated active employees and families (including both HSBP and employee's share), plus an additional 2%. **If the eighteen (18) month period of COBRA Continuation Coverage is extended because of disability, HSBP may charge an increased premium of up to 150 percent of the cost of coverage applicable to the COBRA family unit (but only if the disabled person is covered) during the additional COBRA extension period.**

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may increase when HSBP's COBRA premiums are revised, generally on an annual basis.

IMPORTANT

There will be no invoices or reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Benefits Office.

Grace Periods

Initial Payment

The initial payment for the first month of COBRA Continuation Coverage is due to the Benefits Office **no later than forty-five (45) days** after the date that COBRA Continuation Coverage is elected (the date the election form is submitted). **If you do not submit payment at the time of election of coverage, your coverage will not be continued until payment is received and will terminate as scheduled due to the Qualifying Event.** When initial payment is received in full within forty-five (45) days from the date of election, coverage will be reinstated retroactively to the date that your coverage terminated or was scheduled to terminate. Note that if mailed, payment must be postmarked within forty-five (45) days from the date of election. **If payment is not received or postmarked on or before the last day of the forty-five (45) day grace period, you will no longer be eligible for coverage under HSBP and will have no right to reinstate your benefits**.

Subsequent Monthly Payments

After the initial COBRA payment, subsequent monthly premium payments are due on or before the first day of the month of coverage to which it applies. There is a thirty (30) day grace period to make monthly periodic payments. If payment is not received on or before the first day of the month, your coverage will be suspended as of the end of the period for which the last premium payment was remitted. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted when and if your coverage is reinstated. If you thereafter make a monthly periodic payment in full later than the first day of the coverage period to which it applies but before the end of the thirty-day grace period (the first 30 days of that month), your coverage will be reinstated retroactively to the first day of that month. If any periodic premium payment is not received or postmarked within the thirty (30) day grace period for the coverage period, you will no longer be eligible for coverage under HSBP, and you will have no right to reinstate your benefits.

Confirmation of Coverage before Election or First Payment of the Cost of COBRA Continuation Coverage

If, after you lose coverage due to a Qualifying Event, a health care provider requests confirmation of coverage and you, your spouse or dependent child(ren) are within the sixty (60) day COBRA election period but have not yet elected COBRA or, if you have elected COBRA Continuation Coverage but initial payment has not yet been made and the forty-five (45) day grace period is still in effect, the health care provider will be informed that you, your spouse and/or dependent child(ren) do not currently have coverage but will have coverage retroactively to the date coverage was lost if coverage is elected and/or timely payment is made and that no claims will be paid until the amounts due have been received.

Confirmation of Coverage During a Thirty (30) Day Grace Period

If a health care provider requests confirmation of coverage and the periodic monthly payment for COBRA Continuation Coverage for that period has not been paid and the thirty (30) day grace period is still in effect, the health care provider will be informed that you, your spouse and/or dependent child(ren) do not currently have coverage but will have coverage retroactively to the first day of that month if timely payment is made and that no claims will be paid until the amounts due have been received.

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Benefits Office within thirty-one (31) days to add a spouse or dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee) are enrolled for COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage. The loss of the spouse's or dependent's coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or employee to pay premiums on a timely basis or termination of coverage for cause.

You must enroll the Spouse or dependent within thirty-one (31) days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event HSBP is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Benefits Office, an explanation indicating why COBRA Continuation Coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extending COBRA When a Second Qualifying Event Occurs: If, during an eighteen (18) month maximum period of COBRA Continuation Coverage resulting from loss of coverage because of a Qualifying Event, you die, become divorced (or legally separated), become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a dependent child under HSBP, the maximum COBRA Continuation period for the affected spouse and/or child is extended to thirty-six (36) total months measured from the date of the Qualifying Event resulting in a loss of coverage or the date you first became entitled to Medicare, if that is earlier.

This extended period of COBRA Continuation Coverage in the event of a Second Qualifying Event is <u>not</u> available to anyone who became your spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage *is* available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the eighteen (18) month period of COBRA Continuation Coverage.

In no case is an employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of eighteen (18) months (unless the employee is entitled to an additional period of up to eleven (11) months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a Second Qualifying Event and COBRA may not be extended beyond eighteen (18) months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of thirty-six (36) months.

Notifying the Plan: To extend COBRA when a Second Qualifying Event occurs, you must notify the Benefit Office in writing **within sixty (60) days** of a Second Qualifying Event. Failure to notify HSBP in a timely fashion may jeopardize an individual's right to extended COBRA coverage. The written notice must include your name, the Second Qualifying Event, the date of the Qualifying Event, and the appropriate documentation in support of the Qualifying Event, such as divorce documents.

Extended COBRA Coverage in Certain Cases of Disability During an Eighteen-Month COBRA Continuation Period: If, prior to the initial Qualifying Event or during the first sixty (60) days of an eighteen (18) month period of COBRA Continuation Coverage, the Social Security Administration ("SSA") makes a formal determination that you or a covered spouse or dependent child is disabled within the meaning of Title II or Title XVI of the Social Security Act the disabled person and any Qualified Beneficiar(ies) who so choose, may be entitled to keep the COBRA Continuation Coverage for up to twenty-nine (29) months (instead of eighteen (18) months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if:

- the (SSA) determines that the individual's disability began within the first sixty (60 days of COBRA Continuation Coverage; **and**
- the disability lasts until at least the end of the eighteen (18) month period of COBRA Continuation Coverage.

Notifying the Plan: To extend COBRA in the case of disability, you must notify the Benefits Office in writing **within sixty (60) days** of the later of 1) the date on which SSA issues the disability determination, 2) the date on which the Qualifying Event occurs, or 3) the date on which the Qualified Beneficiary loses (or would lose) coverage under HSBP as a result of the Qualifying Event **and** that notice must be received by the Benefits Office before the end of the 18-month COBRA Continuation period. Failure to notify HSBP in a timely fashion may jeopardize an individual's right to extended coverage. The written notice must include your name, the name of the disabled individual, the date of SSA determination, and appropriate documentation in support of the SSA determination, including the SSA determination.

You must also provide the Benefits Office with a notice of an SSA determination if you or a Qualified Beneficiary is no longer disabled. This notice must be sent **within thirty (30) days** after the date of the SSA determination.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date HSBP no longer provides group health coverage to any participants.
2. The date the amount due for COBRA coverage is not paid in full on time.
3. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA.
4. The date, after the date of the COBRA election, on which the Qualified Beneficiary first begins coverage under another group health plan. IMPORTANT: the Qualified Beneficiary must notify HSBP as soon as possible once they become aware that they will become covered under another group health plan by contacting the Benefits Office. COBRA coverage under HSBP ends on the first day on which the Qualified Beneficiary begins coverage under the other group health plan.
5. During an extension of the maximum COBRA coverage period to twenty-nine (29) months due to the disability of a Qualified Beneficiary, the date, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled.
6. The date HSBP has determined that the Qualified Beneficiary must be terminated from HSBP for cause (on the same basis as would apply to similarly situated non-COBRA employees under HSBP).
7. The participating employer with respect to whom you obtained your coverage in the first place withdraws from HSBP. However, if employer covers a classification of its employees under another group health plan, it must offer COBRA participants enrollment in the new plan for the duration of the eligible COBRA coverage period.

Notice of Early Termination of COBRA Continuation Coverage

HSBP will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated, and any rights the Qualified Beneficiary may have under HSBP to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Benefits Office determines that COBRA coverage will terminate early.

Brief Outline on How Certain Laws Interact with COBRA

FMLA and COBRA: taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA Qualifying Event. A Qualifying Event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the Qualifying Event in most cases, the last day of the FMLA leave. Note that if the employee notifies the participating employer that they are not returning to employment prior to the expiration of the maximum FMLA twelve (12) week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA: if an employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium) or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a Qualified Beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period of eighteen (18), twenty-nine (29), or thirty-six (36) months, the lesser time period can be credited toward covering the 18, 29, or 36-month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six (6) months while on a LOA, the six (6) months can be credited toward the COBRA maximum period.

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contact or contacts identified below. For more information about rights you may have under applicable federal law, contact the Office of the Inspector General of Department of Health and Human Services at (202) 619-3148 or by mail at Cohen Building, Suite 5250, 330 Independence Ave., SW, Washington, DC 20201.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

HSBP Benefits Office is responsible for the administration of COBRA Continuation Coverage and can be reached at the address below:

COBRA Plan Administrator
House Staff Benefits Plan
10-27 46th Avenue, Suite 300-2
Long Island City, NY 11101
Phone (212) 356-8180
Fax: (212) 356-8181
benefits@cirbenefitsfunds.org

CONFIDENTIALITY OF HEALTH CARE INFORMATION

The following describes how medical information about you may be used and disclosed and how you can get access to this information.

By law, the House Staff Benefits Plan is required to protect the confidentiality of your protected health information (PHI), information that constitutes PHI as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The Privacy Regulations cover the disclosure and use of protected health information, your individual rights regarding protected health information and special rules for plan sponsors, employers and service providers to plans. This notice describes how HSBP protects the PHI we have about you and it may use your PHI for purposes of making or obtaining payment for your care and conducting health care operations. HSBP has established a policy to guard against unnecessary disclosure of your PHI. The official *HIPAA Notice of Privacy Practices* is distributed to all participants of HSBP.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like HSBP maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI). The term "Protected Health Information" includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by HSBP in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by an employer who participates in HSBP in its role as an employer.

A complete description of your rights under HIPAA can be found in HSBP's Notice of Privacy Practices, which is distributed to you upon enrollment in HSBP and is also available from the Benefits Office.

HSBP, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information" or "PHI") except as necessary for treatment, payment, health care operations and HSBP plan administration, or as permitted or required by law. In particular, HSBP will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. Except as permitted by HIPAA, HSBP will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. HSBP may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of HSBP.

HSBP's Use and Disclosure of PHI: HSBP will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, HSBP will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. HSBP rarely, if ever, uses or discloses PHI for treatment purposes.

Payment includes activities undertaken by HSBP to obtain premiums or determine or fulfill its responsibility for coverage and provision of HSBP benefits with activities that include, but are not limited to, the following:

a. Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

Health Care Operations includes, but is not limited to:

a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of HSBP, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

c. Underwriting (HSBP does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

e. Business management and general administrative activities of HSBP, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

When an Authorization Form is Needed: Generally, HSBP will require that you sign a valid authorization form (available from the Benefits Office) in order for HSBP to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or HSBP uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

HSBP will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that HSBP plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from HSBP agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This HSBP hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. HSBP requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor (unless authorized by the individual or disclosed in HSBP's Notice of Privacy Practices);

5. Report to HSBP any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining HSBP's compliance with HIPAA;

10. If feasible, return or destroy all PHI received from HSBP that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. If a breach of your unsecured protected health information (PHI) occurs, HSBP will notify you.

In order to ensure that adequate separation between HSBP and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

- The Plan Administrator.
- Staff designated by the Plan Administrator.
- Business Associates under contract to HSBP including but not limited to the vision claims administrator.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by HSBP's Privacy Officer.

If you are a minor and have concerns about HSBP releasing PHI to your parents or guardian, please contact the Benefits Office.

In compliance with HIPAA Security regulations, the Plan Sponsor:

1. Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Will ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

4. Report to HSBP any security incident of which it becomes aware concerning electronic PHI.

HIPAA PRIVACY PRACTICES
OF THE HOUSE STAFF BENEFITS PLAN

The following describes how medical information about you may be used and disclosed and how you can get access to this information.

By law, the House Staff Benefits Plan ("HSBP") is required to maintain the privacy of your Protected Health Information (PHI), information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Regulations cover the disclosure and use of protected health information, your individual rights regarding protected health information and special rules for plan sponsors, employers and service providers to plans. This notice describes how HSBP protects the PHI we have about you and may use your health information for purposes of making or obtaining payment for your care and conducting health care operations. HSBP has established a policy to guard against unnecessary disclosure of your health information.

HSBP **must** use and disclose your PHI to provide information:

1. To you or someone who has the legal right to act for you (your personal representative).
2. To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
3. Where required by law.

HSBP **has the right** to use and disclose you PHI for Payment and Health Care Operations For example:

1. **Payment**. HSBP may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, HSBP may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.
2. **Health Care Operations**. HSBP may use or disclose health information for its own operations to facilitate the administration of the health plan and as necessary to provide coverage and services to all of HSBP's employees.

HSBP **may** use or give out your PHI for the following purposes under limited circumstances:

1. **For Treatment Alternatives and Health-Related Benefits and Services**. HSBP may use and disclose your health information to tell you about or recommend possible treatment options or alternatives and health-related benefits that may be of interest to you.
2. **For Disclosure to the Plan Sponsor (the Trustees of HSBP).** HSBP may disclose your health information to the Plan Sponsor (the Trustees of HSBP) for plan administration functions performed by the Plan Sponsor (the Trustees of HSBP) on behalf of HSBP. In addition, HSBP may provide summary health information to the Plan Sponsor (the Trustees of HSBP) so that the Plan Sponsor (the Trustees of HSBP) may solicit premium bids from health insurers or modify, amend or terminate the plan. HSBP also may disclose to the Plan Sponsor (the Trustees of HSBP) information on whether you are participating in the health plan.
3. **When Legally Required.** HSBP will disclose your health information when it is required to do so by any federal, state or local law.
4. **To Conduct Health Oversight Activities**. HSBP may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. HSBP, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

5. **In Connection with Judicial and Administrative Proceedings**. As permitted or required by state law, HSBP may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when HSBP makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

6. **For Law Enforcement Purposes**. As permitted or required by state law, HSBP may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if HSBP has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

7. **In the Event of a Serious Threat to Health or Safety**. HSBP may, consistent with applicable law and ethical standards of conduct, disclose your health information if HSBP, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

8. **For Specified Government Functions**. In certain circumstances, federal regulations require HSBP to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

9. **For Workers' Compensation**. HSBP may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

By law, HSBP must have your written permission (authorization) to use or disclose your PHI for any other purpose that is not set out in this Notice. If you authorize HSBP to use or disclose your health information, you may revoke that authorization in writing at any time.

You **have the following rights** regarding your health information that HSBP maintains:

1. **Right to Inspect and Copy Your Health Information Held by HSBP**. A request to inspect and copy records containing your health information must be made in writing. If you request a copy of your health information, HSBP may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

2. **Right to Amend Your Health Information**. If you believe that your health information records are inaccurate or incomplete, you may request that HSBP amend the records. That request may be made as long as the information is maintained by HSBP. HSBP may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by HSBP, if the health information you are requesting to amend is not part of HSBP's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if HSBP determines the records containing your health information are accurate and complete.

3. **Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information**. You have the right to request a limit on HSBP's disclosure of your health information to someone involved in the payment of your care. However, HSBP is not required to agree to your request.

4. **Right to Receive Confidential Communications**. You have the right to request that HSBP communicate with you in a certain way if you feel the disclosure of your health information could endanger you. HSBP will attempt to honor your reasonable requests for confidential communications.

5. **Right to Receive a Listing of Those Receiving Your PHI from HSBP**. You have the right to request a list of certain disclosures of your health information, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with HSBP's privacy policies and applicable law. The request must be made in writing, specifying the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years.

6. **Right to a Paper Copy of this Notice.** You have the right to paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive it electronically.

HSBP is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. HSBP is required to abide by the terms of this Notice, which may be amended from time to time. HSBP reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If HSBP changes its policies and procedures, HSBP will revise the Notice and will provide a copy of the revised Notice to you within sixty (60) days of the change. You have the right to express complaints to HSBP and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to HSBP should be made in writing to:

Sheila Blanc
Privacy & Security Officer
House Staff Benefits Plan
10-27 46th Avenue, Suite 300-2
Long Island City, NY 11101
Phone: (917) 994-4033
Email: sblanc@cirbenefitfunds.org

STATEMENT OF PARTICIPANT 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 afford employees the rights described below, which are typically available under ERISA funds. Employees will be entitled to:

- Examine, without charge, at the Fund Administrator's office all HSBP plan documents, including insurance contracts, collective bargaining agreements and other documents such as annual reports and plan descriptions.
- Obtain copies of all HSBP documents and other plan information upon written request to the Fund Administrator. The Fund Administrator may make a reasonable charge for the copies.
- The Trustees who operate your HSBP, called "fiduciaries," recognize that they have a duty to do so prudently and in the interest of you and other HSBP employees and beneficiaries. No one, including your participating 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 HSBP. 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 HSBP review and reconsider your claim and you have a right to appeal the decision to the Board of Trustees.