2015 Health Choice Benefits Guide
This guide summarizes Hospital for Special Surgery’s benefit plans. The actual plan provisions are contained in legal documents and contracts. If there is a discrepancy between the information in this guide and the provisions of the documents and contracts, the terms of the documents and contracts will prevail. Hospital for Special Surgery reserves the right to amend or terminate these benefits at any time. Any such amendments to the plan will be made in writing and adopted by the Board of Trustees. The information in this booklet does not constitute a contract of employment.

Any Questions?
If you have questions, or simply need more information about Health Choice, call the HSS Benefits Team at:

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Welcome to Health Choice

Different people have different benefit needs. Some prefer a particular type of medical plan. Some need more life and accident insurance. Some are looking for ways to save on taxes. You’re the only person who knows which of these features are most important to you. With Health Choice, you can choose among a number of benefit options, so your overall benefits program better reflects your personal situation.

What’s New for 2015

Medical Changes:

- **Oxford Freedom Direct Low Plan closed to new enrollees.** If you are currently enrolled in the Oxford Freedom Direct Low Plan for 2014, you may continue that coverage for 2015.
- **New in-network deductibles, coinsurance and out-of-pocket maximums.** Due to health care trends, your in-network, out-of-pocket costs will increase.
- **Tobacco annual premium surcharge.** If you certified your tobacco status during open enrollment for 2014 you are not obligated to re-certify for 2015 unless your status has changed. If you certified as a tobacco user, you will continue to be assessed the $250 annual premium surcharge.
- **New rates for 2015.** The cost of health care continues to rise, with HSS paying, on average 86% of the cost.
- **Increased Health Savings Account (HSA) Contribution Limits.** For 2015, the IRS has increased your maximum allowable contribution amount to $3,350 for Individuals and $6,650 for Families. After the HSS contributions, this allows you to make optional pre-tax contributions up to $2,600 for single coverage and $5,150 for family coverage.

Prescription Drug Changes:

- **Prescription drug out-of-pocket-maximum.** The amount you pay toward prescription drugs will now count toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year. The 2015 prescription out-of-pocket maximum is $1,500 for Individual coverage and $3,000 for Family coverage. **Note:** If enrolled in Family coverage; once a covered family member reaches the out-of-pocket maximum of $1,500, cost is covered in full for that family member. The CDHP plan will continue to have the combined, medical and prescription out-of-pocket maximum of $6,350 for Individual coverage and $12,700 for Family coverage.
- **Expanding Step Therapy Drug Categories.** The list of prescription drugs covered under the Step Therapy Drug Program is expanding. If you are currently taking a prescription medication that falls under the new program, you will receive further information in the mail from Express Scripts.
- **Prior Authorization Requirements.** Certain prescription medications will now require prior authorization from Express Scripts. If you are currently taking a prescription medication that falls under the new prior authorization requirements, you will receive further information in the mail from Express Scripts.
- **Prescription Drug Quantity Limits.** In 2015, some prescription drugs will be subject to quantity limits. These limits are in place for quality and safety reasons. If you are currently taking a prescription medication that falls under the new quantity limits, you will receive further information in the mail from Express Scripts.

Dental and Vision Plan Changes

- **New dental rates for 2015.** You will see a small increase in your dental contributions.
- **Dental implants now covered in the Voluntary and Traditional Plan.**
- **New vision rates for 2015.** You will see a decrease in your vision contributions.

Become Tobacco-free through Quit for Life

The Quit for Life Program is sponsored by the American Cancer Society® and Alere Wellbeing. These two organizations have 35 years of combined experience in tobacco cessation coaching and have helped more than 1 million tobacco users. The program integrates free medication, web-based learning and confidential phone-based support from expert Quit Coaches®.

The program includes, at no cost to you:

- Up to five outbound coaching calls with a Quit Coach.
- Nicotine replacement therapy (8 weeks of patch/gum) mailed directly to your home if appropriate.
- Access to Web Coach®, a private, online community where you can complete activities, watch videos, track your progress and join in discussions with others in the program.
- An easy-to-use printed workbook that you can reference in any situation to help you stick with your quitting plan.
- Recommendations on type, dose and duration of nicotine replacement or medication if appropriate (including patch, gum, bupropion or Chantix™).
- Text messaging support.
- Unlimited toll-free access to Quit Coaches, who offer as much or as little support as you need.

To enroll or learn more, call 1-866-QUIT-4-LIFE (1-866-784-8453) or visit www.quitnow.net.
If you wish to participate, or continue participation, in the Flexible Spending Accounts, IRS rules require you to make an election each year. You must make this election through the Benefits Administration website – www.hss.bswift.com.

If you enroll in the United Healthcare Consumer Directed Health Plan (CDHP), you are not eligible to participate in the Healthcare Flexible Spending Account.

### Your Health Choice Options

The following is a brief summary of your Health Choice options. Each plan is described in more detail later in this booklet:

- **Medical (United Healthcare or Oxford)** — With Health Choice, you can choose from four different medical options: United Healthcare Choice Plus, United Healthcare Consumer Directed Health Plan (CDHP) with HSA, Oxford Freedom Direct High and Oxford Exclusive Provider Organization EPO. The Oxford Exclusive Provider Organization EPO is the only option that does not offer out-of-network benefits. None of the four options require you to choose a primary care physician. **Note:** The Oxford Freedom Direct Low Plan is closed to new enrollees, but available in 2015 for those currently enrolled.

- **Dental (Guardian)** — The Health Choice Dental Plan offers three options: the Guardian DMO, the Guardian Traditional and the Guardian Optional Voluntary. The Guardian DMO requires that you see an in-network dentist.

- **Long Term Disability (LTD) Insurance (Hartford)** — You will receive basic coverage of 60 percent of your annual salary, with a maximum benefit of $1,200 per month. Plus, you may purchase voluntary coverage if you want additional financial protection. **Elected voluntary coverage outside of your initial enrollment period and during open enrollment will require you to complete the Personal Health Application and submit to Hartford for approval. Coverage will not be effective until the date Hartford approves the application.**

- **Life Insurance (Hartford)** — You will receive basic coverage of one times your salary. You can also elect additional voluntary coverage in increments of $20,000, not to exceed 5 times your salary. The combined basic and voluntary coverage has a maximum benefit of $1.5 million.

- **Accidental Death & Dismemberment Insurance (Hartford)** — You will receive basic coverage of $50,000. You can also elect additional voluntary coverage in increments of $20,000, not to exceed 5 times your salary. The combined basic and voluntary coverage has a maximum benefit of $1.5 million.

- **Health Savings Account (HSA) with the United Healthcare Consumer Directed Health Plan (CDHP).** If you enroll in the United Healthcare Consumer Directed Health Plan, you have access to a Health Savings Account (HSA) to help pay for eligible medical expenses with pre-tax dollars. This account is similar to a Flexible Spending Account (FSA), but with some important differences — such as employer made contributions to your account from HSS in 2015 and the ability to roll over an HSA balance from year to year. Unlike the FSA plans there is no “use it or lose it” rule for the HSA. See the “Health Savings Account” section in this guide for more details.

- **Flexible Spending Accounts (Ultra Benefits)** — You can save on taxes with the Health Care and Dependent Care Spending Accounts. Each account lowers your taxable income by letting you pay for certain expenses with before-tax dollars. The maximum annual contribution for the Health Care Spending Account is $2,500 and $5,000 for the Dependent Care Spending Account (for eligible child care expenses). If you enroll in the UHC CDHP medical plan you are not eligible to participate in the Healthcare Flexible Spending Account.
How *Health Choice* Works

With *Health Choice*, you decide which benefits are right for you and your family. Each option has an employee contribution, which is the amount you contribute toward the cost of your coverage. The employee contributions are listed on the Benefits Administration website [www.hss.bswift.com](http://www.hss.bswift.com).

### The Pre-Tax Advantage

Remember, with *Health Choice*, many of your benefit contributions are made on a pre-tax basis. How much can you save by paying for your medical and dental coverage on a before-tax basis? That depends on a number of factors, including your marital status, number of dependents and annual salary.

Here’s an example. Let’s assume that you’re married with one child and earn $50,000 per year. Let’s also assume that your contributions toward the cost of medical and dental coverage are $3,542 per year.

#### Tax Savings Example

<table>
<thead>
<tr>
<th>Before-Tax Deductions</th>
<th>After-Tax Deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before-tax Payroll</td>
<td>$3,542</td>
</tr>
<tr>
<td>Deductions for Benefits</td>
<td>$0</td>
</tr>
<tr>
<td>Estimated Federal Income and FICA Taxes</td>
<td>$10,522</td>
</tr>
<tr>
<td>Deductions for Benefits</td>
<td>$11,325</td>
</tr>
<tr>
<td>After-tax Payroll</td>
<td>$0</td>
</tr>
<tr>
<td>Deductions for Benefits</td>
<td>$3,542</td>
</tr>
<tr>
<td>Take-home Pay</td>
<td>$35,936</td>
</tr>
<tr>
<td></td>
<td>$35,133</td>
</tr>
</tbody>
</table>

In this example, you will add approximately $800 to your annual take-home pay simply by having your medical and dental payroll deductions made on a before-tax basis. As you consider your options, you should note that you won’t pay Social Security taxes on those before-tax deductions. As a result, your wages reported for Social Security purposes will be marginally reduced, which could slightly lower your Social Security benefit when you retire. In general, however, the immediate tax savings will usually outweigh any reduction in your eventual Social Security retirement benefits.

### Eligible Employees

If you are a regular full-time employee or a part-time employee working at least 20 hours a week, you are eligible for *Health Choice* benefits after you satisfy the applicable waiting period. If you are eligible, you can also elect medical, dental and vision coverage for certain dependents. Your eligible dependents include your:

- Spouse
- Domestic partner (contact Human Resources for eligibility requirements)
- Your children, up to age 26 for medical, prescription, dental and vision coverage
- Physically or mentally disabled children of any age who are totally dependent on you for support.

You will be required to provide proof of status for any new dependents you are enrolling during your new hire or newly eligible initial enrollment and open enrollment. Enrollment for these dependents will be classified in pending status until this documentation is received. Proof of status documentation includes:

- Spouse: Copy of marriage certificate
- Child: Copy of birth certificate
- Domestic Partner: Domestic partner affidavit

### Part-Time Employees

HSS allows part-time employees to participate in the *Health Choice* benefits program. Please be advised that there may be a significant difference in the cost of benefits for part-time employees.

### When Coverage Begins

If you enroll during the open enrollment period, most *Health Choice* coverage begins on the following January 1.

Voluntary Long-Term Disability coverage and Voluntary Life Insurance coverage elected during open enrollment require completion and submission of a Personal Health Application. You will be sent to the Hartford website to complete the Personal Health Application, following completion of your enrollment. Should Hartford approve your application, you will receive notification of the coverage effective date.

### Changing Your Coverage

The choices you make during enrollment remain in place through December 31, 2015.

If you enroll in the UHC CDHP, you can change your HSA contribution during the year through the Benefits Administration website, [www.hss.bswift.com](http://www.hss.bswift.com). You do not have to experience one of the following changes in life status to change your HSA election.

For all other medical, dental, vision, life, accident and disability elections, the following changes in life status allow you to change your benefits:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse or child
- A change in your spouse’s employment which results in loss or gain of coverage
- A change in your employment status from part-time to full-time or full-time to part-time
- Loss of other coverage
Any benefit change that you make must be a direct result of your change in life status. For example, if you get married, you can change your coverage level from individual to family.

You have 30 days from the date of the event to make your change. Please see the chart above for more information or contact Human Resources.

If you acquire a new dependent because of a marriage, birth or adoption, you can enroll yourself and any eligible dependents for medical coverage, even if you have previously waived coverage. In this situation, you must complete a Life Event enrollment through the Benefits Administration website [www.hss.bswift.com](http://www.hss.bswift.com) within 30 days of the marriage, birth, or adoption. You will be eligible to enroll under any medical option or coverage level normally available to you. (Please see chart above.)

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Medical</th>
<th>Dental</th>
<th>Spending Accounts Medical</th>
<th>Dependent Care</th>
<th>Coverage Will Begin or End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>Elect coverage increase</td>
<td>Elect/decline coverage increase</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>increase contribution</td>
<td>Increase/decrease contribution</td>
<td></td>
</tr>
<tr>
<td>Birth or Adoption of a Child</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>Elect coverage increase</td>
<td>Elect/decline coverage increase</td>
<td>Day of the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>increase contribution</td>
<td>Increase/decrease contribution</td>
<td></td>
</tr>
<tr>
<td>Legal Separation or Divorce</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>Elect coverage increase</td>
<td>Elect/decline coverage increase</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>increase contribution</td>
<td>Increase/decrease contribution</td>
<td></td>
</tr>
<tr>
<td>Change in Spouse's Employment or Loss of Spouse's Employment</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>Elect coverage increase</td>
<td>Elect/decline coverage increase</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>increase contribution</td>
<td>Increase/decrease contribution</td>
<td></td>
</tr>
<tr>
<td>Loss of other coverage</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>Elect coverage increase</td>
<td>Elect/decline coverage increase</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>increase contribution</td>
<td>Increase/decrease contribution</td>
<td></td>
</tr>
<tr>
<td>Death of a Spouse or Qualified Dependent*</td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>Elect coverage</td>
<td>Elect/decline coverage increase</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease contribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cease to Qualify as a Dependent*</td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>N/A</td>
<td>Elect/decline coverage increase</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td>Gain/Loss of Domestic Partner’s Employment or Benefits*</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>N/A</td>
<td>N/A</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease coverage</td>
<td>Increase/decrease contribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change of Address (Resulting in a change in medical provider’s service area, which affects your choice of plans)</td>
<td>Elect/decline coverage</td>
<td>Elect/decline coverage</td>
<td>N/A</td>
<td>N/A</td>
<td>First of the month following the event</td>
</tr>
<tr>
<td></td>
<td>Proof of address change required; must satisfy Hospital requirements (driver/s license not acceptable)</td>
<td>Proof of address change required; must satisfy Hospital requirements (driver/s license not acceptable)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See the definition of an eligible dependent on page 6.

Note: Once you enroll in the Medical Flexible Spending Account, you cannot cancel this benefit for the remainder of the plan year.
What Happens If You Don’t Enroll?

If you are currently enrolled, you will continue to receive the benefits you had in effect during 2014, with the exception of the Flexible Spending Accounts and the Health Savings Account, which require an annual election. If you are a new employee with a benefits eligibility date of January 1, 2015 you must enroll through the Benefits Administration Enrollment site during the open enrollment period.

If you don’t complete your enrollment you will be assigned the following elections by default:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Default Election</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Oxford EPO, single coverage level, tobacco use surcharge</td>
</tr>
<tr>
<td>Dental</td>
<td>Guardian DMO, single coverage level</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>Basic coverage of 1 x Salary</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>Basic coverage of $50,000</td>
</tr>
<tr>
<td>Long Term Disability (LTD)</td>
<td>Basic coverage of 60% of monthly salary, to a maximum benefit of $1,200 per month</td>
</tr>
</tbody>
</table>

If you receive default coverage, the necessary contributions will automatically be deducted from your pay plus $250 (annual amount) for the tobacco use surcharge.

Receiving default coverage is not the same as waiving coverage.

If you are covered under another health insurance plan in 2014 and elect not to be covered under Health Choice in 2015, you must elect the “Waive” option on the Benefits Administration website. Failure to complete your enrollment will result in you being enrolled in the default coverage listed in the chart. You will not have the opportunity to waive this coverage until the next open enrollment period.
Knowing Your Terms

The remainder of this booklet describes your various Health Choice options in more detail. To help you understand how each option works, here are some important terms you should know:

**Coinsurance**

The percentage of costs you and the plan each pay, after you meet the deductible. This applies to the Guardian Traditional Dental Plan and to your medical plans after you satisfy the deductible either in or out of network. If your medical plan covers both in- and out-of-network services, your in-network coinsurance will be lower (you'll pay less) than your out-of-network coinsurance.

**Copayment**

This is a flat fee (copay) you pay to your health care provider and prescription provider.

You pay a copayment for office visits, emergency room visits and prescription drugs on all Oxford medical and the United Healthcare Choice Plus Plan when you go to a provider in-network.

**Deductible**

This is the amount you must pay toward your covered expenses each year before the plan begins to pay benefits. Your deductible depends on the coverage level you select — individual or family — and the plan you choose. Depending on your plan, some expenses do require you to first meet the deductible. If your plan covers both in- and out-of-network services, your in-network deductible will be lower than your out-of-network deductible.

**Out-of-Pocket Maximum**

The out-of-pocket maximum is the most you can be required to pay toward your covered expenses each year. In most cases, once this limit is reached, the plan pays 100% of your covered expenses for the rest of that year. (However, you may be responsible for expenses for services not covered by the plan, or amounts in excess of the reasonable and customary limits.)

**Reasonable and Customary Expense Limits**

Reasonable and customary (R&C) limits are the prevailing rates charged for a surgical procedure, medical service or supply, taking into account the geographic area in which the services are provided. When R&C limits apply, reimbursements will not exceed these amounts. You will be responsible for paying the difference between the R&C limit and the rate charged. This does not apply to In-Network providers. Only when you utilize an out-of-network provider does the possibility of you being responsible for paying the amount in excess of the R&C limit apply.
The Medical Plan

The Health Choice Medical Plan protects you and your covered dependents against the high cost of medical care. Under the program, you can choose from four medical options:

- Oxford Freedom Direct High
- Oxford Exclusive Provider Organization (EPO)
- United Healthcare Consumer Directed Health Plan with HSA (CDHP)
- United Healthcare Choice Plus

The Oxford Freedom Direct Low option is closed to new enrollees, but remains open in 2015 for those currently enrolled.

You can also waive coverage entirely if you have coverage from another source.

You can choose coverage for:

- Yourself only (Single Coverage), or
- Yourself and your family (Family Coverage)

Each Health Choice medical option is described in more detail on the pages that follow. Please review this information carefully, so you can choose the medical plan that is right for you and your family.

Preferred Drug Step Therapy

A Preferred Drug Step Therapy program is a “step” approach to providing prescription drug coverage. Preferred Drug Step Therapy is designed to encourage the use of cost-effective prescription drugs when appropriate. To determine if your prescription requires Preferred Drug Step Therapy, or is subject to limitations, call Express Scripts at (800) 818-0093.

If you have a discontinuance or lapse in therapy of more than 130 days while using the brand-name medication and need to restart therapy, you will be subject to another review under the Preferred Drug Step Therapy program to determine if the cost of the brand-name medication will be covered under the Plan. There is no minimum age requirement for Step Therapy.

The Oxford Freedom Direct High Option

The Oxford Freedom Direct High Non-Gated option is similar to a Preferred Provider Organization plan (PPO). If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network.

- In-Network — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no copayment. Non-preventive services are covered as follows:
  - Physician services: The plan pays 100% after a $30 copayment for Primary Care Physicians (PCPs) or a $50 copayment for specialists
  - Emergency Room visit: The plan pays 100% after a $150 copayment
  - For inpatient hospital admission and most other services: The plan pays 95% after you pay an annual deductible of $350 for individual coverage, or $875 for family coverage
  - Once you reach the out-of-pocket maximum ($1,500 per individual, or $3,000 for a family), the plan pays 100% of any remaining costs (medical copayments) for the year.

- Out-Of-Network — If you choose an out-of-network provider, for most services, the plan pays 70% after you satisfy an annual deductible ($1,100 per individual and $2,750 per family). You are responsible for filing claim forms no later than 180 days from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

  Once you reach the out-of-pocket maximum ($4,000 per individual, or $10,000 for a family), the plan pays 100% of any remaining costs for the year (co-insurance). However, you are still responsible for paying 100% of any amounts above the reasonable and customary (R&C) limit an out-of-network provider may charge.

Special Circumstances

The following special circumstances can affect the benefits under the Oxford Freedom Direct High option for you and your covered family members.

- If You Need Emergency Care — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call Oxford within 48 hours at 1-800-444-6222. If you comply with these procedures, your copayment will be waived and you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.
You Must Pre-certify All Surgical or Major Diagnostic Procedures — Except when performed on an emergency basis as previously outlined, regardless of where the procedure is performed. Call Oxford at 1-800-444-6222 at least 14 days in advance. If your surgery or testing is being coordinated by an in-network physician, he or she will make the necessary arrangements with Oxford for you.

If Your Dependent Is a Student Away at School — Under the Oxford Freedom Direct High plan, dependents may see United Healthcare Choice Plus providers throughout the country. Simply call Oxford at the number on the back of your card (1-800-444-6222), and a service representative will direct you to a network provider in the area.

Prescription Drug Benefits Provided by Express Scripts

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs counts toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

In-Network Pharmacies — You pay $10 for generic, $30 for brand name and $50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.

Out-Of-Network Pharmacies — Your prescription drugs will not be covered if you do not use a network pharmacy.

Mail Order Prescriptions — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail order program, you can receive up to a 90-day supply of medication. All you have to pay is $25 for generic, $75 for brand name and $125 for non-formulary drugs.

Brand Name Drugs — If you purchase a brand name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.

In-Network — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no copayment. Non-preventive eligible services will be covered as follows:

- Physician services: The plan pays 100% after a $30 copayment for Primary Care Physicians (PCPs) or a $50 copayment for specialists
- Emergency Room visit: The plan pays 100% after a $150 copayment
- Inpatient hospital admission and most other services: The plan pays 95% after you pay an annual deductible of $350 for individual coverage, or $875 for family coverage
- Once you reach the out-of-pocket maximum ($1,500 per individual, or $3,000 for a family), the plan pays 100% of any remaining costs (medical copays) for the year.

In addition, your physician will submit your claim form to Oxford for reimbursement.

Out-Of-Network — If you choose an out-of-network provider, most services will be covered at 70% after you satisfy an annual deductible ($2,100 per individual and $4,200 per family). You are responsible for filing claim forms no later than 180 days from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

Once you reach the out-of-pocket maximum ($5,000 per individual, or $12,500 for a family), the plan pays 100% of any remaining costs for the year (co-insurance). However, you are still responsible for paying 100% of any amounts above the reasonable and customary (R&C) limit an out-of-network provider may charge.

Special Circumstances

The following special circumstances can affect the benefits under the Oxford Freedom Direct Low option for you and your covered family members.

If You Need Emergency Care — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call Oxford within 48 hours at 1-800-444-6222. If you comply with these procedures, your copayment will be waived and you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.

You Must Pre-certify All Surgical or Major Diagnostic Procedures — Except when performed on an emergency basis as previously outlined, regardless of where the procedure is performed. Call Oxford at 1-800-444-6222 at least 14 days in advance. If your surgery or testing is being coordinated by an in-network physician, he or she will make the necessary arrangements with Oxford for you.
• **If Your Dependent Is a Student Away at School** — Under this plan, dependents may see United Healthcare Choice Plus providers throughout the country. Simply call Oxford at the number on the back of your card (1-800-444-6222), and a service representative will direct you to a network provider in the area.

**Prescription Drug Benefits Provided by Express Scripts**

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs counts toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay $10 for generic, $30 for brand name and $50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.

- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.

- **Mail Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail order program, you can receive up to a 90-day supply of medication. All you have to pay is $25 for generic, $75 for brand name and $125 for non-formulary drugs.

- **Brand Name Drugs** — If you purchase a brand name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.

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**Oxford Freedom EPO Option (EPO)**

The Oxford Exclusive Provider Organization EPO option offers high-quality, cost-effective care through the same network of doctors and hospitals as the Oxford Freedom plans. You do not have to select a primary care provider (PCP), and you do not need a referral to see a specialist. However, you must receive care from providers within the plan’s network (except in emergencies, as described below).

Preventive services are covered 100% with no copayment. For non-preventive services, you pay copayments of only $30 for visits to network primary care physicians (PCPs), $50 for specialists and $150 for Emergency Room.

For in-patient hospital services and most other services, the plan pays 95% after you pay an annual deductible of $350 for Individual, or $875 for Family coverage.

Remember, there is no out-of-network coverage under this plan.

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**Special Circumstances**

The following special circumstances can affect the benefits under the Oxford Exclusive Provider Organization EPO for you and your covered family members.

- **If You Need Emergency Care** — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call Oxford within 48 hours at 1-800-444-6222. If you comply with these procedures, your copayment will be waived and you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.

- **You Must Pre-certify All Surgical or Major Diagnostic Procedures** — except when performed on an emergency basis as previously outlined, regardless of where the procedure is performed. Call Oxford at 1-800-444-6222 at least 14 days in advance. If your surgery or testing is being coordinated by an in-network physician, he or she will make the necessary arrangements with Oxford for you.

- **If Your Dependent Is a Student Away at School** — Under the Oxford EPO plan, dependents may see United Healthcare Choice Plus providers throughout the country. Simply call Oxford at the number on the back of your card (1-800-444-6222), and a service representative will direct you to a network provider in the area.

**Prescription Drug Benefits Provided By Express Scripts**

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs will now count toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay $10 for generic, $30 for brand name and $50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.

- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.

- **Mail Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail order program, you can receive up to a 90-day supply of medication. All you have to pay is $25 for generic, $75 for brand name and $125 for non-formulary drugs.

- **Brand Name Drugs** — If you purchase a brand name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.
The United Healthcare Consumer Directed Health Plan (CDHP) Option with a Health Savings Account (HSA)

The United Healthcare CDHP is designed for individuals and families who wish to plan for their health care needs over the long term. Its unique Health Savings Account (HSA) allows you to accumulate a substantial tax-free balance you can use to pay your eligible out-of-pocket costs for the current year (like deductible and coinsurance), but also save for future eligible expenses, such as health care in retirement.

To offer an HSA, plans like the CDHP must qualify under IRS rules as a "high deductible health plan." As a result, the deductible and out-of-pocket maximum in this plan are higher than in your other options. All non-preventive care (including prescription expenses) is subject to the deductible. If you elect this plan, HSS will make a contribution in 2015 to your HSA equal to half the In-Network deductible.

If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network.

- **In-Network** — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no coinsurance. For non-preventive services, you pay an annual deductible of $1,500 for individual coverage, or $3,000 for family coverage. After you meet the deductible, eligible services will be covered as follows:
  - All other eligible services (other than prescription drugs): The plan pays 80%, and you pay 20% up to the out-of-pocket maximum.
  - Once you reach the out-of-pocket maximum ($6,350 for individual coverage, or $12,700 for family coverage), the plan pays 100% of any remaining costs for the year.
  - In addition, your physician will submit your claim form to UHC for reimbursement.

- **Out-Of-Network** — If you choose an out-of-network provider, for most services the plan pays 60% after you satisfy an annual deductible ($3,000 for individual coverage or $6,000 for family coverage), until you reach the out-of-pocket maximum. Once you reach the out-of-pocket maximum ($8,000 for individual coverage, or $16,000 for family coverage), the plan pays 100% of any remaining costs for the year.

You are responsible for filing claim forms no later than one year from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

Understanding the Family Deductible and Out-of-Pocket Maximum

In the CDHP, the family deductible and out-of-pocket maximum works differently than they do in the other medical plans.

If you elect family coverage in the CDHP, the family deductible and out-of-pocket maximum apply to all covered family members individually and collectively. In other words:

- The plan does not begin paying benefits for any family member until the family deductible has been satisfied.
- The plan does not pay 100% benefits for any family member (other than for preventive) until the family out-of-pocket maximum has been met.

Prescription Drug Benefits Provided by Express Scripts

Under this plan, you pay the full amount for your prescription drugs until you reach the deductible, then the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy.

- **In-Network Pharmacies** — Medications mandated under the Affordable Care Act are covered at 100%, with no deductible. For a list of these medications, as well as all covered medications, please log on to www.express-scripts.com. For all other medications, you pay the full price of all prescriptions until you reach the deductible. Once you reach the deductible, you pay a copayment of $10 for generic, $30 for brand name and $50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.

- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy, even once you have satisfied your deductible.

- **Mail Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail order program, you can receive up to a 90-day supply of medication, but you will still pay the full cost of your prescriptions. Once you satisfy the deductible, all you have to pay is $25 for generic, $75 for brand name and $125 for non-formulary drugs.

- **Brand Name Drugs** — If you purchase a brand name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.
Health Savings Account (HSA)

Only the CDHP offers a Health Savings Account (HSA) that:

- Includes contributions from HSS of $750 for the year if you elect individual coverage and $1,500 for the year if you elect family coverage. That’s like having HSS pay half your deductible for 2015.
- Allows you to make optional pre-tax contributions to the account up to the following maximum:
  - Single Coverage: $2,600 (additional $1,000 if age 55+)
  - Family Coverage: $5,150 (additional $1,000 if age 55+)
- Offers a triple tax advantage: all money goes in tax-free, grows tax-free, and remains tax-free when withdrawn to pay eligible expenses.
- Allows you to roll over unused balances from year to year. Unlike a Flexible Spending Account (FSA), there is no “use it or lose it” rule for the HSA. In fact, the money in your account remains yours if you change plans or leave the Company for any reason.

Review the HSA section of this Guide to learn more.

The United Healthcare Choice Plus

If you elect medical coverage under this option, your benefits will be based on where you receive care. Each time you need care, you may choose whether to receive care in-network or out-of-network.

- **In-Network** — If you choose an in-network provider, preventive services are covered 100%, with no deductible and no copayment. Eligible non-preventive services will be covered as follows:
  - Physician services: The plan pays 100% after a $30 copayment for Primary Care Physicians (PCPs) or specialists
  - Emergency Room visit: The plan pays 100% after a $150 copayment
  - Inpatient hospital admission and most other eligible non-preventive services: The plan pays 100% after you pay an annual deductible of $350 for individual coverage, or $875 for family coverage.
  - Other eligible services (other than prescription drugs): The plan pays 95%.
  - Once you reach the out-of-pocket maximum ($3,000 per individual, or $6,000 for a family), the plan pays 100% of any remaining costs for the year.

In addition, your physician will submit your claim form to United Healthcare for reimbursement.

- **Out-Of-Network** — If you choose an out-of-network provider, for most services, the plan pays 70% after you satisfy an annual deductible ($600 per individual and $1,500 per family). You are responsible for filing claim forms no later than one year from the date of service and obtaining pre-authorization of inpatient, outpatient and mental health services. Out-of-network providers may also bill you for amounts above the reasonable and customary (R&C) fee limits established by the plan.

Once you reach the out-of-pocket maximum ($5,000 per individual, or $10,000 for a family), the plan pays 100% of any remaining costs for the year. However, you are still responsible for paying 100% of any amounts above the reasonable and customary (R&C) limit an out-of-network provider may charge.

**Special Circumstances**

The following special circumstances can affect the benefits under the United Healthcare Choice Plus option for you and your covered family members.

- **If You Need Emergency Care** — You should seek treatment immediately at the nearest emergency facility. If you are treated and directly admitted to the facility from the emergency room, you must call United within 48 hours at 1-866-527-9597. If you comply with these procedures, you will receive in-network benefits for your hospital stay. Failure to comply could adversely affect the benefit you receive.

- **When You’re Away From Home** — If you’re traveling and require emergency medical care, call the number on the back of your ID card, 1-866-527-9597, and a service representative will direct you to a network provider in the area.

- **If Your Dependent Is a Student Away at School** — Under the United Healthcare Choice Plus plan, dependents may see local United providers throughout the country. Simply call the number on the back of your ID card, 1-866-527-9597, and a service representative will direct you to a network provider in the area.
Prescription Drug Benefits Provided By Express Scripts

Under this plan, the amount you pay for prescription drugs depends on whether you go to an in-network or out-of-network pharmacy. The amount you pay toward prescription drugs will now count toward an out-of-pocket maximum. Once you reach that maximum the plan pays 100% for prescription drugs for the rest of the year.

- **In-Network Pharmacies** — You pay $10 for generic, $30 for brand name and $50 for non-formulary drugs, whether prescribed by an in-network or out-of-network doctor.

- **Out-Of-Network Pharmacies** — Your prescription drugs will not be covered if you do not use a network pharmacy.

- **Mail Order Prescriptions** — If you have long-term prescription needs (such as high blood pressure or diabetes medication), you can also have your prescriptions filled by mail. Under the mail order program, you can receive up to a 90-day supply of medication. All you have to pay is $25 for generic, $75 for brand name and $125 for non-formulary drugs.

- **Brand Name Drugs** — If you purchase a brand name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.

Comparing Your Medical Options

The charts on the next pages highlight your medical options. Out-of-network benefit percentages (what the plan pays) under the United Healthcare Choice Plus and Freedom Direct High options are based on reasonable and customary (R&C) expenses as described on page 9.

**Please note:** The charts provide only a summary of medical benefits. The actual Summary Plan Description will be the governing document for the plan. This is only a summary of medical benefits. The actual Summary Plan Description (SPD) will be the governing document for the plan. The SPD’s are available on the Benefits Administration website – [www.hss.bswift.com](http://www.hss.bswift.com) – in the News and Library section.

Pre-Admission Review (All Medical Options)

Pre-Admission Review is a service that helps you determine both the necessity and duration of any inpatient hospital stay. Each carrier has a pre-admission review organization. The idea behind pre-admission review is to ensure that you receive the best possible medical care and to find out if any alternative treatments might be appropriate.

**How Pre-Admission Review Works**

- **United Healthcare** — You must call United Healthcare at 1-866-527-9597 at least 48 hours before a scheduled admission and within 48 hours after an emergency admission to receive full benefits.

- **Oxford Health Plans** — You must call Oxford at 1-800-444-6222 at least 14 days before a scheduled admission and within 48 hours after an emergency admission to receive full benefits.
## Advanced Services

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<td><strong>In-Network</strong></td>
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<td>In-Network Only</td>
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<td><strong>Annual Deductible</strong></td>
<td>$1,500 individual, $3,000 family*</td>
<td>$3,000 individual, $6,000 family*</td>
<td>$350 per individual, $1,500 per family</td>
<td>$350 per individual, $875 per family</td>
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<td><strong>Annual Out-of-Pocket Limit</strong> (including copays, coinsurance and deductible)</td>
<td>$6,350 individual, $12,700 family*</td>
<td>$8,000 individual, $16,000 family*</td>
<td>$3,000 per individual, $10,000 per family</td>
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<tr>
<td><strong>Physician Office Visits (PCP/Specialist)</strong></td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 80%. You pay deductible plus 40% coinsurance</td>
<td>Plan pays 100% after $30/$50 copayment</td>
<td>Plan pays 100% after $30/$50 copayment</td>
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<td><strong>Hospitalization</strong></td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
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<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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<td><strong>Surgeon’s Fee</strong></td>
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<td>Plan pays 80%. You pay deductible plus 40% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 5% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 5% coinsurance</td>
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<td><strong>Emergency Room Treatment</strong></td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 80%. You pay deductible plus 40% coinsurance</td>
<td>$150 copayment (waived if admitted)</td>
<td>$150 copayment (waived if admitted)</td>
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<td><strong>Routine Physical Examination (19 years of age and older)</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 60%. You pay deductible plus 40% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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<td><strong>Mammography Screening/PAP Smear</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 60%. You pay deductible plus 40% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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<td><strong>Well Child Care</strong></td>
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<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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<td><strong>Infertility Services Basic / Comprehensive</strong></td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 60%. You pay deductible plus 40% coinsurance</td>
<td>Office visit: Plan pays 100% after $30 copayment</td>
<td>Office visit: Plan pays 100% after $30 copayment</td>
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<td><strong>Advanced Infertility - Office</strong></td>
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<td>Not covered</td>
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Note: Deductible is $1,000 per individual in the family. Coinsurance is 50% in the family. Maximum out-of-pocket benefit is $3,000 per individual, $6,000 per family. Maximum lifetime benefit is $10,000 per individual, $20,000 per family.
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<tr>
<td>Outpatient facility</td>
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<td>Outpatient visit: Plan pays 95%. You pay deductible plus 5% coinsurance</td>
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<tr>
<td>Routine Nursery</td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 60%. You pay deductible plus 40% coinsurance</td>
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<td>Physician Visits, Room &amp; Board</td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 60%. You pay deductible plus 40% coinsurance</td>
<td>Plan pays 95%. You pay deductible plus 5% coinsurance</td>
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<td>Outpatient</td>
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<td>Alcohol &amp; Substance Abuse</td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 95%. You pay deductible plus 5% coinsurance</td>
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<td>Inpatient Treatment</td>
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<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
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<td>Outpatient Use Disorders Treatment</td>
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<td>Alcohol &amp; Substance Abuse</td>
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<td>Inpatient Treatment</td>
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<td>Diagnostic X-ray and Lab Service</td>
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<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 95%. You pay deductible plus 5% coinsurance</td>
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<td>Skilled Nursing Facility</td>
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<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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<td>Physical Therapy &amp; Rehab Inpatient</td>
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<td>Plan pays 80%. You pay deductible plus 20% coinsurance</td>
<td>Plan pays 95%. You pay deductible plus 5% coinsurance</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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<td>In-Network</td>
<td>Out-of-Network</td>
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<td>Out-of-Network</td>
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<td><strong>Plan pays 80%. You pay deductible plus 20% coinsurance for up to 30 visits per calendar year</strong></td>
<td>Plan pays 60%. You pay deductible plus 40% coinsurance</td>
<td>$30 copayment for up to 30 visits per calendar year</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
<td>$50 copayment for up to 90 visits combined per calendar year</td>
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<tr>
<td><strong>Plan pays 70%. You pay deductible plus 30% coinsurance</strong></td>
<td>$50 copayment for up to 90 visits combined per calendar year</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
<td>$50 copayment for up to 90 visits combined per calendar year</td>
<td>Plan pays 70%. You pay deductible plus 30% coinsurance</td>
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| Prescription Out-of-Pocket Maximum | N/A | N/A | $1,500 individual $3,000 family | $1,500 individual $3,000 family | $1,500 individual $3,000 family |

| Prescription Drugs (Express Scripts Pharmacies only): Retail | After deductible is satisfied, $10 copay for generic drugs, $30 copay for brand name drugs, $50 copay for non-formulary drugs. Once deductible is satisfied, 100% after $25 copay for generic drugs, $75 copay for brand name drugs, $125 copay for non-formulary drugs. | Not covered | 100% after $10 copay for generic drugs, $30 copay for brand name drugs, $50 copay for non-formulary drugs | 100% after $10 copay for generic drugs, $30 copay for brand name drugs, $50 copay for non-formulary drugs | 100% after $10 copay for generic drugs, $30 copay for brand name drugs, $50 copay for non-formulary drugs |
| Mail Order: 2.5x retail copay (up to 90-day supply) | Not covered | 100% after $25 copay for generic drugs, $75 copay for brand name drugs, $125 copay for non-formulary drugs | Not covered | 100% after $25 copay for generic drugs, $75 copay for brand name drugs, $125 copay for non-formulary drugs | Not covered | 100% after $25 copay for generic drugs, $75 copay for brand name drugs, $125 copay for non-formulary drugs |

| Lifetime Maximum | Unlimited |

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1. If you purchase a brand name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference in cost between the generic and brand name.
2. Under the United Healthcare CDHP and Choice Plus Plan, there is a combined limit on the number of days of skilled nursing facility and inpatient physical therapy.
3. Under the Oxford High and Oxford Low and EPO options, there is a combined limit of 210 days per lifetime for Hospice care.
4. Under the UHC CDHP and Choice Plus plan there is a combined limit of 360 days per lifetime for Hospice Care
5. If enrolled in Family coverage; once a covered family member reaches the out-of-pocket maximum of $1,500, cost is covered in full for that family member.
Examples

The following examples show what you might pay for a typical maternity claim and for a high-cost claim. Both examples assume:

- You enroll in individual coverage
- All services are provided in-network
- The total cost in the chart represents the plan-allowed fees for both hospital and physician expenses
- The were no other claims to date, so the in-network deductible had not previously been satisfied

Maternity Claim — $15,000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>- Deductible</td>
<td>- $1,500</td>
<td>- $250</td>
<td>- $250</td>
<td>- $250</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$13,500</td>
<td>$14,750</td>
<td>$14,750</td>
<td>$14,750</td>
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<tr>
<td>Coinsurance (your share)</td>
<td>x 20%</td>
<td>x 0%</td>
<td>x 0%</td>
<td>x 0%</td>
</tr>
<tr>
<td></td>
<td>$2,700</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Your total cost</td>
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<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>- HSA contribution from HSS</td>
<td>- $750</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Your net cost</td>
<td>$3,450</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
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</table>

<table>
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<th></th>
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</tr>
</thead>
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<tr>
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<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>- Deductible</td>
<td>- $1,500</td>
<td>- $350</td>
<td>- $350</td>
<td>- $350</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$13,500</td>
<td>$14,650</td>
<td>$14,650</td>
<td>$14,650</td>
</tr>
<tr>
<td>Coinsurance (your share)</td>
<td>x 20%</td>
<td>x 5%</td>
<td>x 5%</td>
<td>x 5%</td>
</tr>
<tr>
<td></td>
<td>$2,700</td>
<td>$732</td>
<td>$732</td>
<td>$732</td>
</tr>
<tr>
<td>Your total cost</td>
<td>$4,200</td>
<td>$1,082</td>
<td>$1,082</td>
<td>$1,082</td>
</tr>
<tr>
<td>- HSA contribution from HSS</td>
<td>- $750</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Your net cost</td>
<td>$3,450</td>
<td>$1,082</td>
<td>$1,082</td>
<td>$1,082</td>
</tr>
</tbody>
</table>
## High-Cost Claim — $75,000

### 2014 Plan Designs

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost</td>
<td>$75,000</td>
<td>$75,000</td>
<td>$75,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>- $1,500</td>
<td>- $250</td>
<td>- $250</td>
<td>- $250</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$73,500</td>
<td>$74,750</td>
<td>$74,750</td>
<td>$74,750</td>
</tr>
<tr>
<td>Coinsurance (your share)</td>
<td>x 20%</td>
<td>x 0%</td>
<td>x 0%</td>
<td>x 0%</td>
</tr>
<tr>
<td>Deductible + coinsurance</td>
<td>$14,700</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Out-of-pocket maximum</td>
<td>$6,350</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>HSA contribution from HSS</td>
<td>- $750</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Your net cost</td>
<td>$5,600</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
</tr>
</tbody>
</table>

### 2015 Plan Designs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost</td>
<td>$75,000</td>
<td>$75,000</td>
<td>$75,000</td>
<td>$75,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>- $1,500</td>
<td>- $350</td>
<td>- $350</td>
<td>- $350</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$73,500</td>
<td>$74,650</td>
<td>$74,650</td>
<td>$74,650</td>
</tr>
<tr>
<td>Coinsurance (your share)</td>
<td>x 20%</td>
<td>x 5%</td>
<td>x 5%</td>
<td>x 5%</td>
</tr>
<tr>
<td>Deductible + coinsurance</td>
<td>$14,700</td>
<td>$3,732</td>
<td>$3,732</td>
<td>$3,732</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td>$6,350</td>
<td>$3,000</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>HSA contribution from HSS</td>
<td>- $750</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Your net cost</td>
<td>$5,600</td>
<td>$3,000</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

*Exceeds annual out-of-pocket maximum. Plan pays 100% of eligible expenses above this limit.*
**Coordination of Benefits**

If you’re covered under more than one health care plan, you may be paying for coverage you don’t need. That’s because of a provision known as “coordination of benefits,” which applies to out-of-network coverage under the United Healthcare Choice Plus and Oxford Freedom Direct plans.

With coordination of benefits, if you or one of your dependents is covered by more than one plan, the combined payments of both plans cannot exceed the amount HSS would normally pay if Health Choice was your only source of coverage. For example, if your spouse also has coverage under his or her employer’s plan, any expenses he or she incurs must be submitted to the other plan first. If that plan pays 80% of the expenses, Health Choice will not pay any additional benefits. However, if your spouse’s plan pays less than what Health Choice would normally pay, your HSS plan will pay the difference. There are no special coordination-of-benefit provisions for the Oxford Exclusive Provider Organization, the Guardian DMO dental option, or for in-network coverage under the United Healthcare Choice Plus or the Oxford Freedom Direct plans.

**Understanding Out-of-Network**

Under the United Healthcare Choice Plus and the Oxford Freedom Direct High option, benefits for out-of-network medical care are based on the plan’s usual, customary and reasonable (UCR) charge for each service. If a physician or other medical provider charges more than the UCR, you may be billed for the excess amount, along with your coinsurance percentage.

The plans use different measurements to set their UCR rates, which can mean different out-of-pocket costs for you.

- For the Choice Plus and Direct High option, UCR is based on information from the Health Insurance Association of America, which surveys doctors every six months on their fees. The UCR is set at 80% of the range for your geographic area.
- All out-of-network claims must be submitted within six months of the date of service. Claims submitted late will be denied.

**Notification Required for Certain United Healthcare Services**

With the UHC plans, notification is required before receiving certain covered health services. Network providers are responsible for this notification for in-network services. However, you are responsible for notification if you seek services from an out-of-network provider. If you do not provide this notification, you may be assessed a penalty charge when you seek any of the following treatments:

- Ambulance
- Congenital Heart Disease/ Congenital Treatment at Centers of Excellence
- Hospital – Inpatient stay
- Outpatient Therapeutics Treatment
- Clinical Trials
- Transplantation Services/ Transplantation Services at certain Designated Facilities
- Chiropractic Services
- Dental – Accident
Currently, HSS provides a 50% discount off balances due after payment by your insurance carrier to inpatient and outpatient services rendered by the hospital. You can greatly minimize your financial responsibility for services received at the Hospital by utilizing HSS physicians who participate in your health plan.

**Part-Time Employees**

HSS allows part-time employees to participate in the *Health Choice* benefits program. Please be advised that there may be a significant difference in the cost of benefits for part-time employees.

**Switching Plans?**

If you switch to an Oxford health plan (or enroll for the first time), Oxford offers a transitional care benefit. If you are receiving care for a life-threatening, degenerative or disabling condition – or you are in the 2nd or 3rd trimester of pregnancy – and your health care provider is not part of the Oxford network, Oxford may provide network level benefits for up to the first 60 days or through the end of postpartum care. Your doctor should call Oxford at 800-666-1353 for information.
The Dental Plan

Unlike most medical expenses, dental expenses are fairly predictable and rarely catastrophic. At the same time, however, dental expenses can add up quickly, especially when routine care is neglected. That’s why the Health Choice Dental Plan is designed to help you and your family take care of your routine dental needs while also ensuring that you’re covered for more serious dental expenses.

Health Choice offers three dental options that cover the same types of services but have different deductibles, different benefit maximums, and different restrictions on which dentists you can see. You can also waive dental coverage entirely, if you prefer.

The Guardian Traditional Option

The Guardian Traditional Option is designed for people who want the freedom to visit any dentist they choose. This option has a lower premium when compared to the Optional Voluntary Dental Plan, but has a lower annual benefit of $1,600.

The Guardian Optional Voluntary Dental Plan

The Guardian Optional Voluntary Dental Plan is designed for people who want the freedom to visit any dentist they choose. This option has higher premiums when compared to the Traditional Option, but has an increased annual benefit of $3,000.

How the Guardian Traditional and Optional Voluntary Dental Plans Work

Under the two Guardian dental plan options, you decide whether to see a network dentist or a non-network dentist. Usually you pay less when you see a network dentist because these dentists agree to charge lower fees for their services. Regardless of whether you see a network or non-network dentist, each covered individual must pay a deductible before receiving benefits for Basic, Major and Orthodontia Services. The deductible is waived for Diagnostic and Preventive Services.

The annual deductible is:

- $50 if you see an in-network dentist (deductible is waived for in-network preventive care)
- $100 if you see an out-of-network dentist

After the deductible has been met, the plan pays benefits based on the type of dental services received.

- Diagnostic and Preventive Services — Both plans pay 80% of eligible expenses for oral exams, emergency treatment for pain, and biennial x-rays twice a year, six months apart, as well as other routine diagnostic and preventive services.
- Basic Services — Both plans pay 80% of eligible expenses for basic dental services such as fillings, extractions, gum surgery, and root canals.
- Major Services — Both plans pay 50% of eligible expenses for major dental services such as dentures, bridges, and crowns.
- Orthodontia Services — The plan pays 50% of eligible expenses for orthodontia services such as appliances and orthodontic x-rays.

Maximum Benefits

The Guardian Traditional Option has a $1,600 annual benefit for each individual enrolled. The Guardian Optional Voluntary Plan has a $3,000 annual benefit for each individual enrolled. Both plans offer a $1,000 per lifetime orthodontia benefit for each covered individual.

The Guardian DMO Option

The Guardian DMO is a Dental Maintenance Organization (DMO) that offers quality dental care at a low cost through a network of participating dentists.

How the Guardian DMO Works

If you elect coverage under the Guardian DMO, you must select a primary care dentist from a network of providers. If you don’t, you will be assigned one (based on your home zip code) by Guardian. Once you receive your dental ID card you will need to contact Guardian if you wish to select a different primary care dentist. Then, whenever you need dental care, your treatment must be coordinated by the Guardian dentist you selected. When you use your Guardian dentist, there are no deductibles to pay, no annual benefit maximums, and no claim forms to file. In fact, many of your basic dental services will be provided to you at no charge whatsoever. Other services will require reasonable specified copayments. On the other hand, if you receive care from a non-participating dentist, you will not be eligible for any benefits at all.

Maximum Rollover Accounts Add Value to Dental Benefits

The Maximum Rollover Account, or MRA, allows you to save unused benefit dollars for future years, to have in reserve when you really need them.

Guardian will automatically create an MRA for every HSS employee with Traditional or Optional Voluntary coverage – at no cost to you. This account will hold earned benefit dollars from those years in which your dental expenses are less than the plan’s claims threshold. You may use these dollars to cover services in future years, when your dental expenses exceed the plan maximum. Eligible plan members who utilize in-network dentists will receive more dollars than those who receive out-of-network services.

Guardian will maintain an MRA for every HSS employee and covered dependent in the Traditional or Voluntary plan.
Optional Plans. To qualify for a rollover, the employee or dependent must submit a claim of $1 or more without exceeding the paid-claims threshold during the year (see following chart). MRAs are capped at $1,500 (Optional Voluntary) or $1,250 (Traditional). If you drop your Guardian coverage, you lose the MRA benefit – there is no payout or rollover option to another dental plan. The following chart summarizes the MRA by plan. Guardian will provide you with an annual MRA statement, detailing any activity within the account.

**MRAs: An Example**

Here is an example of how an MRA works, based on membership in the Guardian Traditional Dental Plan:

**Year 1**

- MRA: $0
- Paid Claims: $400 (includes out-of-network)

Paid claims are less than the $700 threshold so $350 is added to the MRA for Year 2.

**Year 2**

- MRA: $350
- Paid Claims: $900 (includes out-of-network)

Paid claims exceed the $700 threshold. Therefore, no additional amount is added to the MRA for Year 3. None of the MRA is used.

**Year 3**

- MRA: $350
- Paid Claims: $1,900 (includes out-of-network)

Paid claims exceed the $1,600 annual benefit maximum so $300 of the MRA is used. No additional amount is added to the MRA because paid claims exceed the $700 threshold.

**Year 4**

- MRA: $50
- Paid Claims: $1,650 (includes out-of-network)

Paid claims exceed the annual benefit maximum by $50, thereby eliminating the remainder of the MRA. No additional amount is added to the MRA because paid claims exceed the $700 threshold.

**Year 5**

- MRA: $0
- Paid Claims: $400 (all in-network)

Paid claims are less than the $700 threshold. $500 is added to the MRA for Year 6 because the member received all eligible services from in-network providers.

### Maximum Rollover by Plan Types

<table>
<thead>
<tr>
<th>Plan</th>
<th>Maximum Annual Benefit</th>
<th>Paid Claims Threshold</th>
<th>Maximum Rollover Amount</th>
<th>Maximum In-Network Rollover Amount</th>
<th>MRA Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardian Traditional Dental Plan</td>
<td>$1,600</td>
<td>$700</td>
<td>$350</td>
<td>$500</td>
<td>$1,250</td>
</tr>
<tr>
<td>Guardian Optional Voluntary Dental Plan</td>
<td>$3,000</td>
<td>$1,000</td>
<td>$500</td>
<td>$750</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

### Pre-Determination of Benefits

If you see a network dentist there is no need to file for pre-determination of benefits. However, if you see a non-network dentist and your dental treatment under the Traditional option is expected to cost more than $300, it is recommended that you file for a pre-determination of benefits before the work begins. That way, you can find out in advance how much the plan will pay. You may also find out if another course of treatment might be more cost-effective. To receive a pre-determination of benefits, simply ask your dentist to fill out a claim form and check the box indicating you want an estimate of your benefits. You'll receive a notice of whether the treatment is covered and how much the plan will pay.

### The No Coverage Option

If you prefer, you can also waive your Health Choice dental coverage entirely.

### Comparing Your Dental Options

The following chart highlights your dental options. Benefit percentages under the Traditional option are based on reasonable and customary expenses as described on page 9. However, if you use a network dentist, benefit percentages are based on pre-negotiated fees that are usually below the reasonable and customary expenses.
Under Health Choice, your dental plan is a separate choice from your medical plan. In other words, you can enroll for a medical plan, a dental plan, both, or neither.
The Vision Plan

Hospital for Special Surgery believes good eyesight is an important part of your overall health, which is why a Vision Plan is included among your Health Choice benefits options. It is not necessary to enroll in either a medical or dental plan to enroll in the Vision Plan.

The Vision Plan is offered by Davis Vision, Inc., one of the nation’s leading administrators of vision-care programs.

How the Vision Plan Works

The Vision Plan is a PPO. You enjoy a higher level of benefits for services received at in-network vision-care providers. Basic services, such as examinations and most eyewear purchases are covered in full after a $10 copayment.

You may choose your eyewear, including spectacles and frames, from a list of pre-approved products. If you choose a frame not included on the pre-approved list, you will receive a credit of up to $130, plus a 20% discount, toward the purchase of that frame. You must pay the difference.

Contact lenses are also available. You pay the $10 copayment for standard models or receive a credit of up to $130 for non-standard models, plus a 15% discount toward the purchase of the contact lenses.

Your benefits decrease at out-of-network providers. You must pay the provider upfront and then file a claim with Davis Vision for reimbursement.

Overview of Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Reimbursement*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Examinations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once per 12 months (including dilation as indicted)</td>
<td>$10 copayment</td>
<td>Up to $40</td>
</tr>
<tr>
<td><strong>Eyeglasses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spectacle lenses (every calendar year)</td>
<td>$10 copayment for spectacle lenses and/or frames</td>
<td>Up to $45 for frames</td>
</tr>
<tr>
<td>Frames (every two calendar years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designer selection from “The Collection” available at most network providers. Up to a $130 allowance and a 20% discount toward any other frame at network provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision spectacle lenses</td>
<td>Covered in full</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Bifocal spectacle lenses</td>
<td>Covered in full</td>
<td>Up to $60</td>
</tr>
<tr>
<td>Trifocal spectacle lenses</td>
<td>Covered in full</td>
<td>Up to $80</td>
</tr>
<tr>
<td><strong>Contact Lenses (per dispensation)</strong></td>
<td>$10 copayment</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Once per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard, soft daily-wear, or planned replacement contact lenses, may be chosen in lieu of eyeglasses. You may receive up to a $130 credit, plus 15% discount for lenses from the provider’s own collection or 8 boxes of disposable lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medically necessary contact lenses (prior approval required)</td>
<td>Covered in full</td>
<td>Up to $210</td>
</tr>
</tbody>
</table>

* You must pay upfront for services from out-of-network providers and then file a claim for reimbursement.

** Once fitted and purchased, contact lenses may not be exchanged for eyeglasses.

Pre-determination of Benefits

To arrange services, call the in-network provider of your choice and schedule an appointment. Tell him or her at that time that you’re a member of a Davis Vision Plan through the Hospital for Special Surgery. You also need to give the provider your participant’s ID number and the name and birth date of any covered dependents to receive services. The provider will pre-determine your benefit with Davis Vision. You won’t need to file any claims paperwork.

Other Services

The Vision Plan covers a wide variety of spectacles, frames and contact lenses, including mail-order contact lenses. The plan also offers discounts to eligible members for laser vision correction services. Please visit the Davis Vision website or call their customer service number for more details.
The Long-Term Disability Plan

Long-term disability (LTD) coverage protects you and your family financially if a serious illness or injury prevents you from working for an extended period of time. The plan begins to pay benefits after you’ve been disabled for 26 consecutive weeks. You must be a regular full-time employee to be eligible for LTD coverage. If you have not yet enrolled in Voluntary LTD coverage you can do so during open enrollment.

Following your enrollment, you will be sent to the Hartford website to complete the Personal Health Application. Should The Hartford approve your application, you will receive notification of the coverage effective date. If you don’t complete the Personal Health Application your request for coverage will be denied.

Health Choice offers two types of LTD coverage.

- Basic — If you are eligible for LTD coverage, you will be automatically enrolled in the Basic LTD Plan. Basic LTD coverage replaces 60% of your monthly salary, with a maximum monthly benefit of $1,200. HSS pays the full cost of your Basic LTD coverage.

- Voluntary — If you earn more than $24,000 per year, you can increase your LTD coverage amount. Voluntary LTD coverage also replaces 60% of your monthly salary above $24,000, but with a maximum monthly benefit of $13,800. The maximum combined monthly Basic and Voluntary benefit you may receive is $15,000. The cost of the Voluntary LTD coverage will be presented in the Voluntary LTD enrollment page on the Health Choice online enrollment site.

How the LTD Plan Works

Duration of Benefits

Benefits normally last until you recover, or until you reach age 65 or your Social Security Normal Retirement age, whichever comes first. However, if you become disabled at age 63 or older, the maximum benefit period will be determined as shown below:

<table>
<thead>
<tr>
<th>Age At Disability</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 63</td>
<td>To Social Security Normal Retirement Age* or 42 months, whichever is longer</td>
</tr>
<tr>
<td>63</td>
<td>To Social Security Normal Retirement Age* or 36 months, whichever is longer</td>
</tr>
<tr>
<td>64</td>
<td>36 months</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 or older</td>
<td>12 months</td>
</tr>
</tbody>
</table>

* Social Security Normal Retirement Age is determined by the rules of the United States Social Security Act (as revised in 1983). It is determined by your birth year. For example, if you were born in the years 1943 - 1954, your Social Security Normal Retirement Age is 66 years old.

How Your Benefits Are Calculated

Let’s assume you earn $24,000 per year. That means your basic monthly earnings are $2,000 ($24,000 divided by 12). If you are totally disabled for more than 26 weeks, your monthly LTD benefit will be $1,200 (60% of $2,000), reduced by payments from other sources as outlined in “Things to Consider.”

Note: Benefits for the portion of Voluntary LTD coverage that you pay for will be tax-free.

How Your Cost Is Calculated

The Hospital pays the entire cost of the basic LTD benefit of $1,200. If you elect additional Voluntary LTD coverage, your cost will be based on your age and your annual salary.

Things to Consider

Under Health Choice, your monthly LTD benefit will be reduced by any payments you receive from other sources, such as Social Security and Workers’ Compensation. This means that if your monthly LTD benefit is $1,200 and you receive $400 from other sources, the Health Choice LTD Plan will pay $800, bringing your total benefit to $1,200.
The Life Insurance Plan

The Health Choice Life Insurance Plan helps protect your family’s financial future if you die. The amount of your coverage depends on the life insurance option you elect. All HSS regular employees must be covered by a life insurance option.

How the Life Insurance Plan Works

Health Choice offers multiple levels of coverage. You’ll receive Basic coverage equal to your annual salary. Plus, you may elect Additional coverage in increments of $20,000, not to exceed 5 times your salary. The maximum combined Basic and Additional benefit is $1,500,000. The price for each option is based on your age and salary. The cost for basic coverage will be paid in full by HSS. During your new hire enrollment period the guaranteed issue amount (combined basic and voluntary election) is 5 times your salary, not to exceed $1,000,000. The following chart outlines your life insurance coverage levels:

<table>
<thead>
<tr>
<th>Life Insurance Coverage Level Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic: 1 x salary</td>
</tr>
<tr>
<td>Additional: $20,000 increments</td>
</tr>
</tbody>
</table>

How Your Benefits Are Calculated

If you earn $50,000 a year and select $60,000 in Additional coverage, your total life insurance coverage amount will equal $110,000 ($50,000 + $60,000). If your Basic coverage amount is not a round number, it will be rounded up to the next highest multiple of $1,000.

How Your Cost Is Calculated

The Hospital pays the full cost of Basic life insurance coverage equal to one times your annual salary. If you elect voluntary additional coverage, your cost will be based on your age and the amount of additional coverage you elect.

Increasing Your Coverage

You have the option of increasing your coverage during open enrollment. Following completion of enrollment, you will be sent to the Hartford website to complete the Personal Health Application. Should the Hartford approve your application, you will receive notification of the coverage effective date. If you don’t complete the Personal Health Application, your request for coverage will be denied.

Reduction in Benefits Due to Age

If you are age 70 or older, your life coverage is reduced to 50 percent of the original amount.

Naming Your Beneficiaries

Your beneficiaries are the people who will receive payment from the plan if you die. You can name your beneficiaries on the online Benefits Administration website.

How Benefits Are Paid To Your Beneficiaries

If you die while covered by the plan, benefits will be paid to your beneficiaries in a single lump-sum payment. If any of your primary beneficiaries are no longer living, your life insurance benefits will be divided equally among your remaining beneficiaries. If all of your primary beneficiaries are no longer living, your life insurance benefits will be divided equally among your contingent beneficiaries, unless otherwise specified.

Changing Your Beneficiaries

Because your family situation is always subject to change, you’re free to change your life insurance and accidental death & dismemberment beneficiaries at any time. You can change your beneficiaries through the Benefits Administration website, www.hss.bswift.com.

Tax Considerations

If your annual salary is more than $50,000, any amount of Basic (Hospital-paid) life insurance coverage in excess of $50,000 is considered imputed income by the IRS. Imputed income is considered taxable income, just like your regular pay. It is shown on your biweekly pay stub and will be included as taxable income on your W-2 form.
The Accidental Death & Dismemberment Plan

The Health Choice Accidental Death & Dismemberment (AD&D) Plan provides an additional way to protect you and your family financially. Benefits are paid if you die in an accident or are seriously injured in an accident (seriously injured means you suffer the loss of sight, hearing, speech, or a limb).

How the AD&D Plan Works

Health Choice offers multiple levels of coverage. You’ll receive Basic coverage equal to $50,000. Plus, you may elect Additional coverage in increments of $20,000, not to exceed 5 times your salary. The maximum combined Basic and Additional benefit is $1,500,000. The cost of your Additional coverage is based on your age and salary. The cost for Basic coverage will be paid in full by HSS.

The following chart outlines your AD&D options:

<table>
<thead>
<tr>
<th>AD&amp;D Coverage Level Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic: 1 x salary</td>
</tr>
<tr>
<td>Additional: $20,000 increments</td>
</tr>
</tbody>
</table>

How Your Benefits Are Calculated

If you die in an accident, your designated beneficiaries will receive 100% of your coverage amount. If you are seriously injured in an accident, the plan will pay benefits based on the following schedule:

<table>
<thead>
<tr>
<th>If You Lose</th>
<th>The Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your speech and hearing</td>
<td>100% of your coverage amount</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100% of your coverage amount</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100% of your coverage amount</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100% of your coverage amount</td>
</tr>
<tr>
<td>Sight in one eye, and lose one hand or one foot</td>
<td>100% of your coverage amount</td>
</tr>
<tr>
<td>One foot or one hand</td>
<td>50% of your coverage amount</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>50% of your coverage amount</td>
</tr>
<tr>
<td>Thumb and index finger on same hand</td>
<td>25% of your coverage amount</td>
</tr>
</tbody>
</table>

Benefits for serious injuries will be paid directly to you, not to your beneficiaries. To be eligible for benefits, the loss must occur within one year of an accident and be directly caused by that accident.

Reduction in Benefits Due to Age

If you are age 70 or older, your AD&D coverage is reduced to 50 percent of the original amount.
The Health Savings Account

The Health Savings Account (HSA) is a special, tax-advantaged savings account offered only to participants in the United Healthcare Consumer Directed Health Plan (CDHP). You can use your HSA to offset out-of-pocket health care costs this year, or save it for the future.

An HSA is similar in some ways to a Flexible Spending Account but with some important differences. Here are the key features:

- **A triple tax advantage.** HSA money is tax free when it enters the plan and when it grows through investment earnings. And, it remains tax free when it is withdrawn — as long as you use it to pay eligible health care expenses (refer to the box below for more information).

- **Immediate ownership.** All contributions to your HSA, including contributions from HSS, are immediately yours to keep.

- **No risk of forfeiture.** Any unused amount at the end of a plan year rolls over to the next year. Unlike a Flexible Spending Account, there is no “use it or lose it” rule.

- **Portability.** If you change plans, retire or leave HSS for any reason, you keep your account balance.

- **Investment options.** Once you reach a certain balance in your HSA, you can choose from the account’s options for investing your balance. Interest and investment earnings are also tax-free. If you elect the CDHP/HSA option contact the HSA bank (Optum Bank) at 1-800-791-9361 for details.

- **Easy withdrawals.** Your HSA is your own personal account. Unlike an FSA, you do not have to file a claim for reimbursement.

### Contributions

In order to receive the HSS contribution and to have your voluntary contribution deposited to your account, you must first open a bank account through Optum Bank. As part of the Open Enrollment process you will be presented with the Optum Bank site link.

For 2015, HSS will contribute:

- $750 if you elect individual coverage
- $1,500 if you elect family coverage.

HSS will fund this contribution as follows:

- January 2015: 50% ($375 for Single Coverage and $750 for Family Coverage)
- July 2015: the remaining annual contribution ($375 for Single Coverage and $750 for Family Coverage)

*You must be employed and enrolled in the UHC CDHP Plan and have an active HSA bank account (Optum Bank) on those funding dates to receive the HSS contribution.

If you make optional contributions yourself, the maximum annual pre-tax amount you and HSS combined can contribute to your account is determined by the IRS, as follows:

<table>
<thead>
<tr>
<th>Coverage level</th>
<th>IRS Combined Maximum for 2015</th>
<th>HSS contribution for 2015</th>
<th>Amount You Can Contribute for 2015*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,350</td>
<td>$750</td>
<td>$2,600</td>
</tr>
<tr>
<td>Family</td>
<td>$6,650</td>
<td>$1,500</td>
<td>$5,150</td>
</tr>
</tbody>
</table>

* If you are age 55 and older in 2015, you may make an additional catch-up contribution of up to $1,000 per year.

### Eligibility

To participate in the HSA, you must be covered by the UHC CDHP through HSS. In addition, you may not participate in a Health Savings Account (HSA) if you:

- Have a Health Care Flexible Spending Account (FSA), or your spouse participates in a Health Care FSA
- Are claimed as a tax dependent of another individual
- Are eligible for Medicare
- Have medical plan coverage other than a high deductible health plan, including coverage under your spouse or domestic partner’s plan.

### Using your HSA

Accessing HSA funds is easy. Within 7-10 days of opening your account, you’ll receive a Debit MasterCard card by mail.

Once you activate the card, you can use it to pay for doctor’s office visits at the time of the appointment or for qualified items at the pharmacy or other retailer.
Eligible Expenses

The IRS determines what expenses qualify for reimbursement from an HSA. Eligible expenses include:

- Deductibles and coinsurance
- Prescribed medications
- Mental health specialist visits and prescriptions
- Ambulance service, chiropractor, X-rays
- Dental cleaning, sealants, fluoride treatments, extractions, orthodontia
- Eye exams, contact lenses, eyeglasses, eye surgery

See IRS Publications 502 and 969 on www.IRS.gov/publications for information about eligible HSA expenses.

IMPORTANT – IRS rules do not allow you to be reimbursed for expenses through an HSA for non tax-qualified dependents. For example, if you enroll a domestic partner in the High Deductible Health Plan, he/she must be a tax-qualified dependent in order to have his/her expenses reimbursed through an HSA. We suggest that you seek guidance from your personal tax advisor to confirm the eligibility of any dependents for whom you plan to submit HSA expenses.
The Flexible Spending Accounts

The Flexible Spending Accounts help you stretch your health care and dependent care budgets. That’s because these accounts let you use tax-free dollars to pay for eligible health care and dependent care expenses.

The money you contribute to the Flexible Spending Accounts is free of federal income, Social Security, and New York State and city taxes. You don’t pay tax on the money you deposit in the accounts, and you don’t pay tax on the reimbursements you receive from your account.

How the Flexible Spending Accounts Work

There are two separate Flexible Spending Accounts: the Health Care Spending Account and the Dependent Care Spending Account (for eligible child care expenses). You may choose to participate in one, both, or neither account. Your participation in the Flexible Spending Accounts is voluntary and funded entirely by you. As with all your other Health Choice benefits, your participation will start on January 1 and end on December 31, unless you have a qualifying change in life status (see page 6, Changing Your Coverage).

Your Dependents

For the purposes of the Health Care Spending Account, your dependents are your spouse, your children, or anyone else you claim as a dependent on your tax return.

For the purposes of the Dependent Care Spending Account, your qualified dependents are your children under age 13 or any dependent who is physically or mentally incapable of caring for himself or herself, as long as you claim them as dependents on your tax return.

Eligible Expenses

The worksheets on the next page contain a partial listing of eligible expenses.

To participate in the Flexible Spending Accounts:

- **Estimate your expenses** — Using the worksheets on the next page, figure out what your unreimbursed medical expenses and your dependent care expenses will be for the coming year.

- **Decide on your deposit and complete your enrollment form** — The plan limits the amount you can contribute to the Health Care Spending Account to $2,500 a year. The IRS limit for the Dependent Care Spending Account is $5,000 a year if single or married and filing a joint tax return; or $2,500 if married and filing an individual return. The minimum you can contribute to either account is $100 per year. Special limits apply if you are married; see page 32 for more information.
### Flexible Spending Account Worksheets

Use the worksheets below to estimate what your health care and dependent care expenses will be for the year. This will help you determine how much you should deposit into the Flexible Spending Accounts.

Your Flexible Spending Accounts enrollment does not automatically renew from year to year. Regardless of your past participation, you must re-enroll for 2015 to participate.

#### Health Care Spending Account Worksheet

<table>
<thead>
<tr>
<th>Your Health Care Expenses (maximum annual contribution: $2,500)</th>
<th>Estimated Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical plan deductibles</td>
<td>$</td>
</tr>
<tr>
<td>Amounts not paid by any medical plan (such as copayments and coinsurance)</td>
<td>$</td>
</tr>
<tr>
<td>Amounts for medical services above R&amp;C</td>
<td>$</td>
</tr>
<tr>
<td>Other non-reimbursable medical expenses (such as private hospital rooms, nursing services, acupuncture, etc.)</td>
<td>$</td>
</tr>
<tr>
<td>Dental plan deductibles</td>
<td>$</td>
</tr>
<tr>
<td>Amounts not paid by any dental plan (including copayments, coinsurance, and orthodontic expenses over plan limits)</td>
<td>$</td>
</tr>
<tr>
<td>Amounts for dental services above R&amp;C</td>
<td>$</td>
</tr>
<tr>
<td>Other non-reimbursable dental expenses</td>
<td>$</td>
</tr>
<tr>
<td>Vision care expenses (such as for exams, contact lenses, frames, and lenses)</td>
<td>$</td>
</tr>
<tr>
<td>Hearing care expenses (such as for exams and hearing aids)</td>
<td>$</td>
</tr>
<tr>
<td><strong>Your Total Estimated Health Care Expenses</strong></td>
<td>$</td>
</tr>
</tbody>
</table>

You, your spouse, your children, or anyone else you claim as a dependent on your tax return may incur these expenses, regardless of whether they are covered under a Health Choice medical or dental option. If you have questions or concerns about the eligibility of certain medical expenses, you may wish to consult a tax advisor.

Please call Human Resources if you have questions concerning eligible expenses.

#### Dependent Care Spending Account Worksheet

<table>
<thead>
<tr>
<th>Your Eligible Child Care Expenses (maximum annual contribution: $5,000*)</th>
<th>Estimated Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments to licensed dependent care centers (for children or adults), nursery schools, after-school programs and day camps that meet state and/or local regulations, provide care for more than six nonresident people and receive fees for services provided</td>
<td>$</td>
</tr>
<tr>
<td>Wages or salary paid to an individual (other than a family member) for care provided in or outside your home</td>
<td>$</td>
</tr>
<tr>
<td>Expenses for household services (such as preparing meals) related to the care of an eligible dependent</td>
<td>$</td>
</tr>
<tr>
<td>Social Security (FICA) and other taxes you pay on behalf of a care/service provider</td>
<td>$</td>
</tr>
<tr>
<td><strong>Your Total Estimated Health Care Expenses</strong></td>
<td>$</td>
</tr>
</tbody>
</table>

Please call Human Resources if you have questions concerning eligible expenses.

* The following special limits apply if you are married:

<table>
<thead>
<tr>
<th>If this is your situation...</th>
<th>Then your maximum annual contribution is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You or your spouse earn less than $5,000</td>
<td>The amount the lower-paid spouse earns</td>
</tr>
<tr>
<td>Your spouse also participates in a similar dependent care account</td>
<td>$5,000 combined</td>
</tr>
<tr>
<td>You file separate federal income tax returns</td>
<td>$2,500</td>
</tr>
<tr>
<td>Your spouse is a full-time student for at least 5 months of the year or is disabled</td>
<td>$2,500 if you have one dependent; $5,000 if you have 2 or more dependents</td>
</tr>
</tbody>
</table>
Completing Your Online Enrollment


Your Best Tax Advantage

Under current tax law, you can pay for eligible dependent care expenses with before-tax dollars through the Dependent Care Spending Account, or you can claim a tax credit for dependent care costs when you file your federal tax return. You may use both approaches, but you can’t “double deduct” for the same expense.

In addition, the amount of expenses that will qualify for a tax credit will be reduced dollar for dollar — by any amount you receive from the Dependent Care Spending Account.

This means:

- If you have one dependent, total expenses eligible for the tax credit are $3,000 (or your actual expenses, if less) minus any amount received through the Dependent Care Spending Account. If you contribute the maximum $2,500 to the Dependent Care Spending Account, this would leave $500 eligible for the tax credit.

- If you have two or more dependents, total expenses eligible for the tax credit are $6,000 (or your actual expenses, if less) minus any amount received through the Dependent Care Spending Account. If you contribute the maximum $5,000 to the Dependent Care Spending Account, this would leave $1,000 eligible for the tax credit.

For specific advice about your situation, you should contact a tax specialist.