THE CONSOLIDATED EDISON, INC.

RETIREE HEALTH PROGRAM

INCLUDING

THE CONSOLIDATED EDISON RETIREE DRUG PLAN

Funded in Part By:

Consolidated Edison Company of New York, Inc. Master VEBA Retiree Health Trust

Consolidated Edison Master VEBA Retiree Health Trust for Weekly Employees

Orange and Rockland Utilities, Inc. Management Retirees Group Insurance Plan and Its VEBA

Orange and Rockland Utilities, Inc. Hourly Retirees Group Insurance Plan and Its VEBA and

The 401(h) Accounts in the Consolidated Edison Retirement Plan

- **Amended April 2003 for the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996**
- **Amended April 2005 for the Transaction Standards of the Health Insurance Portability and Accountability Act of 1996**
- **Amended September 2005 to take into Account the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 And other Administrative Modifications and Clarifications**
- **Amended June 2009 to Specifically Include the Orange and Rockland Utilities, Inc. Management and Hourly Retirees**
- **Amended in January 2008 to Provide for Same-Sex Domestic Partner Benefits**
- **Amended in 2012 for "Total Rewards", Adoption of EGWP, Elimination of Same-Sex Domestic Partner Benefits and Adoption of Same-Sex Spouses and Other Administrative Changes**

Amended in 2014 for Changes Resulting from Local 503 Collective Bargaining Agreement dated June 1, 2014 to June 2017

227232 version 11 is amended and restated as of January 2015.

.

TABLE OF CONTENTS

Page

ARTICLE I Definitions 14

1.01 Annual Deductible 14
1.02 Benefit Period 14
1.03 Board 14
1.04 Board of Directors 14
1.05 Board of Trustees 14
1.06 Care Coordination 14
1.07 Cash Balance Participant 15
1.08 CECONY 15
1.09 CECONY Retiree 15
1.10 CECONY Transferred Employee 15
1.11 CEI 15
1.12 CEI Affiliates 15
1.13 Charge(s) 15
1.14 CMS 16
1.15 COBRA 16
1.16 COBRA Coverage 17
1.17 Code 17
1.18 Coinsurance 17
1.19 Company 17
1.20 Concurrent Care Claim 17
1.21 Contribution 17
1.22 Co-payment 18
1.23 Covered Dependent 18
1.24 Covered Service 18
1.25 Custodial Care 18
1.26 Dependent 18
1.27 Dependent Child 19
1.28 Disability or Disabled 19
1.29 Effective Date of the Program 19
1.30 Eligibility Date 20
1.31 Emergency Care 20
1.32 Employee 20
1.33 Employer 20
1.34 Employer Group Waiver Plan (EGWP) 20
1.35 ERISA 20

1.36 Experimental, Investigational, or Unproven Service 20
1.37 Fiduciary 21
1.38 Government Plan 22
1.39 Group 22
1.40 HMO 22
1.41 Injury 22
1.42 Investment Manager 22
1.43 Lifetime Maximum 22
1.44 MMA 23
1.45 Master Health Plan 23
1.46 Medical Expert 23
1.47 Medicare 23
1.48 Medicare Eligible Participant 23
1.49 Medicare Part D 23
1.50 Named Fiduciary 23
1.51 Network 24
1.52 Network Provider 24
1.53 Non Medicare Eligible Participant 24
1.54 Non Network Provider 24
1.55 O&R 24
1.56 O&R Local 503 Retiree 24
1.57 O&R Management Retiree 24
1.58 O&R Retiree 24
1.59 Part B Expenses 25
1.60 Participant 25
1.61 Pension 25
1.62 Plan Administrator 25
1.63 Plan Year 25
1.64 Post-service Claim 25
1.65 Prescription Benefit Manager (PBM) 26
1.66 Pre-service Claim 26
1.67 Qualified Beneficiary 26
1.68 Qualifying Event 26
1.69 Reasonable and Customary Charge, Maximum Reimbursable Amount, Medicare Allowable Amount, and/or Pre-negotiated Rate or Contract Amount 27
1.70 Recovery 27
1.71 Rehabilitative Care 27
1.72 Reimbursement 27
1.73 Retiree 27
1.74 Retiree Health Plan 28
1.75 Retirement Plan 28

1.76 Sickness 28
1.77 Spouse 28
1.78 Surviving Spouse 28
1.79 Subrogation 28
1.80 Third Party Administrator 28
1.81 Trust Agreement 28
1.82 Trustee 29
1.83 Trust Funds 29
1.84 Urgent Care Claim 29
1.85 VEBA 29
1.86 Year of Service 29

ARTICLE II Eligibility and Eligibility Date 30

2.01 Eligibility 30
2.02 Eligibility Date 32
2.03 Special Eligibility Rules for Medicare Part D Eligible Participants 34

ARTICLE III Summary of Retiree Health Program 36

And Participant's Costs 36

3.01 Retiree Health Program Summary of Covered Services 36
3.02 Organization of Retiree Health Program 36
3.03 Participant's Costs 37
3.04 Cash Balance Participants' Costs 37
3.05 Defined Contribution Pension Formula Participants' Costs 37
3.06 Deductibles 37
3.07 Co- payments and Co- insurance 38

ARTICLE IV Retiree Health Plan 40

4.01 The Retiree Health Plan: In General 40
4.02 Inpatient Stays: Covered Services 40
4.03 Medical Benefits: Deductibles, Coinsurance, and Copayments 45
4.04 Medical Benefits: Covered Services 46
4.05 Physical Examinations and Immunizations for a Dependent Child 52
4.06 Service Covered at 100% With Deductible 52
4.07 Services Covered at 100% 53
4.08 Services Not Covered Under The Retiree Health Plan 53
4.09 Care Coordination 57

ARTICLE V Medicare 59

5.01 Medicare Benefits 59
5.02 Medicare Part D and the Prescription Drug Plan 60

ARTICLE VI Vision Care Benefits 61

6.01 Vision Care Benefits 61

ARTICLE VII Prescription Drug Plan 63

7.01 Prescription Drug Plan 63
7.02 Deductible for Coverage Under Prescription Drug Plan 63
7.03 Co-payments Under the Prescription Drug Plan 63
7.04 Maintenance Prescription Drugs 64
7.05 Refills 64
7.06 Network Pharmacies 65
7.07 Non-Network Pharmacies 65
7.08 Prescription Drug Exclusions 65

ARTICLE VIII Coordination of Benefits, Subrogation and Recovery 66

8.01 Coordination of Benefits 66
8.02 Coordination of Benefits and the Order of Payment 67
8.03 Refund of Overpayments 69
8.04 Subrogation 69

ARTICLE IX Effect of Medicare and Other Government Plans 72

9.01 Medicare 72
9.02 When the Program is Primary to Medicare 72
9.03 Medicare Primary to the Program 72
9.04 Medicare Enrollment Requirements 72
9.05 How The Retiree Health Program Pays When Medicare Is Primary 73
9.06 Government Programs (Other than Medicare and Medicaid) 73

ARTICLE X Contributions 74

10.01 Retiree Contributions 74
10.02 Company Contribution 74

ARTICLE XI Termination of Coverage 76

11.01 When Coverage Ends 76
11.02 COBRA Coverage 78
11.03 Notification Requirements and Election Period for COBRA Coverage 78

11.04 COBRA Terminating Events 79
11.05 Certificate of Creditable Coverage 80
11.06 Form of Certificate 80
11.07 Creditable Coverage Certificates No Longer Required 81

ARTICLE XII Trust Fund 82

12.01 Funding 82
12.02 Special Rule for 401(h) Account 82

ARTICLE XIII Administration and Claims 83

13.01 Authority 83
13.02 Investment Manager 83
13.03 Rights and Duties 83
13.04 Records and Reports 84
13.05 Plan Administrator's Duties and Powers 84
13.06 Plan Expenses 85

ARTICLE XIV Claims Procedure 86

14.01 Claims Procedure for Certain Claims Brought After January 1, 2003 86
14.02 Claims Procedure for Certain Claims Brought After January 1, 2003 87
14.03 Appeals of Adverse Benefit Determinations 89
14.04 Manner and content of Notification of Determination of Review or Appeal 90
14.05 Claims Under HMO 91

ARTICLE XV Termination or Amendment 92

15.01 Termination or Amendment 92

ARTICLE XVI HIPAA Compliance 93

16.01 Use and Disclosure of Protected Health Information - In General 93
16.02 Use and Disclosure for Payment Purposes 93
16.03 Use and Disclosure for Operations Purposes 94
16.04 Use and Disclosure as Required by Law and as Permitted by the Retiree 95
16.05 Consolidated Edison Company of New York, Inc. - Plan Sponsor 95
16.06 Adequate Separation Between the Plan and the Plan Sponsor 96
16.07 Protection of Electronic Protected Health Information 96

ARTICLE XVII Retiree Drug Subsidy and Prescription Drug Plan 98

17.01 General Provisions 98
17.02 Maintain Records 98
17.03 Requirements for Prescription Drug Plan to Qualify for the Subsidy 98
17.04 Creditable Coverage 99

ARTICLE XVIII General Provisions 101

18.01 General Provisions 101

PREAMBLE

The Consolidated Edison Retiree Health Program (the "Program" or "Retiree Health Program") was first established on January 1, 1986, by Consolidated Edison Company of New York, Inc. (the "Company" and/or "CECONY"). The Program was established to offer access to medical care to those employees who retire from the Company and satisfy certain age and service requirements. The Program is intended to qualify as an ERISA employee welfare benefit plan and an employer group health plan under the Internal Revenue Code of 1986, as amended (the "Code") Sections 105 and 5000.

On January 1, 1986, two substantially similar "401(h) Accounts" were established by the Company in the Consolidated Edison Company of New York, Inc. Retirement Plan for Management Employees ("Management Retirement Plan") and in the Consolidated Edison Pension and Benefits Plan ("Weekly Retirement Plan") in order to fund post-retirement medical benefits for certain management and weekly employees, respectfully. The terms, conditions and provisions of the Programs were set forth and incorporated within the Management Retirement Plan ("Management Retiree Health Program") and the Weekly Retirement Plan ("Weekly Retiree Health Program"). The Management Retiree Health Program provided health care benefits to retired management employees of the Company and the Weekly Retiree Health Program provided health care benefits to retired employees of the Company who were members of the following collective bargaining units: Local 1-2, Utility Workers Union of America, AFL-CIO ("Local 1-2"), and Local 3, International Brotherhood of Electrical Workers, AFL-CIO ("Local 3"). The Company provides the Weekly Retiree Health Program under collective bargaining agreements with Local 1-2 and with Local 3.

Effective December 31, 1992, the Company established a trust known as the Consolidated Edison Company of New York, Inc. Master VEBA Retiree Health Trust (the "Master VEBA Retiree Health Trust") under a trust agreement between the Company and State Street Bank and Trust Company, as trustee, to fund the benefits under the Management Retiree Health Program and the Weekly Retiree Health Program and to pay for the cost of current expenses. The proportionate interests of the Management Retiree Health Program and the Weekly Retiree Health Program in the Master VEBA Retiree Health Trust were separately accounted for since the inception of the Master VEBA Retiree Health Trust. Effective June 1, 1999, the Company transferred the proportionate interest of the Weekly Retiree Health Program in the Master VEBA Retiree Health Trust to a newly created trust called the Consolidated Edison Master VEBA Retiree Health Trust for Weekly Employees ("Weekly VEBA Retiree Health Trust"). Thereafter, the Company continues to maintain two separate trust funds. The IRS has recognized both the Master VEBA Retiree Health Trust and the Weekly VEBA Retiree Health Trust as Internal Revenue Code Section 501(c)(9) tax-exempt voluntary employees beneficiary associations. The Weekly VEBA Retiree Health Trust has been recognized by the IRS as a plan maintained under a collective bargaining agreement.

Effective January 1, 2001, solely for administrative and operational efficiencies, the terms, conditions and provisions of the Retiree Health Programs were separated from the Management Retirement Plan and the Weekly Retirement Plan and set forth in this separate single Program and document. The underlying terms, conditions, and provisions of the Program, including the benefits, services, treatments, costs, expenses, deductibles, and providers for the management retirees and the union retirees are identical in all respects. The Master VEBA Retiree Health Trust, the Weekly VEBA Retiree Health Trust and the 401(h) Account continue to remain separately accounted.

Benefits provided under the Program are funded through and paid by a combination of Company contributions, participants' contributions, the 401(h) Accounts, the Master VEBA Retiree Health Trust and the Weekly VEBA Retiree Health Trust, as the Company, in its sole discretion, determines.

Although sponsoring and contributing towards the cost of the Program, the Company does not have and has not in the past had, any legal or statutory obligation and has not made any promise written or oral, to any employee, retiree, dependent or other participant to continue the Program or the employer contribution for any fixed period of time, any specified contribution level, or for the life of any particular participant. As of its establishment date, the Company has reserved and continues to reserve the right at any time and for any reason to change or terminate the Program or to increase or decrease its contributions in whole or in part. The Company also reserves the right to change: the benefits offered, the service providers, the funding mechanisms, and the insurers, from time to time, as it determines in its sole discretion. The Company reserves the right to change its level of funding at any time and for current and future participants. The Company also reserves, at any time and from time to time, the right to make changes to (i) the design of the Program; (ii) the descriptions and explanations and coverage; and (iii) each cost-sharing provision, such as deductible amounts, copayments, coinsurance, and contributions that are set forth in this document. The Plan Administrator has the absolute and full discretion to operate and administer the Program and make determinations.

On January 15, 2002, the Board of Trustees approved and adopted a limit on the Company contribution, if any, that the Company will make to the Program beginning in 2008. The limit will be applied to each participant currently and in the future covered under the Program; provided, however, that the limit will not apply to those participants whose monthly Pension as of the January, 2008, is less than or equal to $1,000.

Effective beginning April 14, 2003, the Program was amended to take into account and comply with the requirements of the Privacy Standards of the Administrative Simplification Provisions of the Health Insurance Portability and Accessibility Act of 1996, as amended ("HIPAA"). Effective October 15, 2003, the Program was amended to take into account and comply with the Transaction Standards of HIPAA.

The Retiree Health Program includes a Retiree Health Plan, various HMOs, a vision care component, and a Prescription Drug Plan. Hospitalization and major medical benefits are made available through a choice of the Retiree Health Plan or an HMO. A Participant who is not eligible for Medicare and chooses the Retiree Health Plan will be covered by a preferred provider organization. A Participant who is Medicare eligible will have hospitalization and major medical benefits coordinated with Medicare. Each Participant, regardless of Medicare status, may elect coverage under the HMO for hospitalization, major medical and prescription drug benefits. A Participant who elects the Retiree Health Plan may also elect coverage under the Prescription Drug Plan or may elect only Prescription Drug Plan Coverage.

Effective April 20, 2005, the Program was amended to take into account the requirements of HIPAA related to the proper disclosure of any electronic Protected Health Information disclosed to the Plan Sponsor by the Plan (or by a health insurance issuer or HMO with respect to the Plan).

Effective as of January 2004, in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), the health care actuary for the Prescription Drug Plan determined that the Prescription Drug Plan is actuarially equivalent to Medicare Part D.

If the Company decides to continue the Prescription Drug Plan, each Participant who is eligible for Medicare Part D beginning January 1, 2006, annually, will have to

decide whether to participate in the Prescription Drug Plan or Medicare Part D, as more fully described below.

On or about January 1, 2008, in an effort to ease administration and efficiency, the Program was updated to include the Orange and Rockland Utilities, Inc. Management Retirees Group Insurance Plan and the Orange and Rockland Utilities, Inc. Hourly Retirees Group Insurance Plan (in the aggregate, the "O&R Retiree Plans"). The O&R Retiree Plans are funded in part by the Orange and Rockland Utilities, Inc. Management Employees' Welfare Benefit VEBA Trust Fund and the Orange and Rockland Utilities, Inc. Hourly Employees' Welfare Benefit VEBA Trust Fund.

O&R is the plan sponsor for the O&R Retiree Plans and has the authority to amend, terminate, modify, revise, and change the O&R Retiree Plans, within the limits of the law. O&R may choose to maintain and sponsor other Plan Options. In general, when the term "Company" is used, effective as of January 1, 2008, Company means CECONY for Retirees of CECONY and O&R for Retirees of O&R.

Effective January 1, 2008, the Retiree Health Program was amended to permit an eligible Retiree who has a same-sex domestic partner to elect to cover him or her with certain restrictions.

Effective July 2010, CECONY and O&R filed applications to the US Department of Health and Human Services ("HHS") to participate in the Early Retiree Reimbursement Program ("ERRP") which was established by the Patient Protection and Affordable Care Act. ERRP provides reimbursement for employment –based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents. The Secretary of HHS will reimburse plans for certain claims between $15,000 and $90,000 for incurred on or after June 21, 2010. On September 17, 2010, the Office of the Secretary of HHS informed CECONY and O&R that our

applications have been approved. Participation in ERRP did not require any amendments to the Retiree Health Program.

Effective January 1, 2012, same sex domestic partners not already covered and included as Dependents in the Retiree Health Program are no longer considered eligible Dependents. Effective January 1, 2012, the term "spouse" and "surviving spouse" includes a same sex spouse. Effective January 1, 2013, same sex domestic partner benefits are no longer available.

Effective January 1, 2013, as a result of the Board of Trustees, Board of Directors of CEI, and the Board of Directors of O&R, adopting recommendations resulting from the Total Rewards project, the Consolidated Edison Inc. Retiree Health Program (the "Program") was amended to take into account the following changes. Effective January 1, 2013, a Retiree, Employee, Participant, or any other individual who is eligible to participate in the Retiree Health Program and was covered under the cash balance formula ("Cash Balance Participant") under the Retirement Plan will be required to pay for the total cost of coverage under the Retiree Health Program. Also, effective and beginning January 1, 2014, O&R will contribute, if at all, to the Retiree Health Program in accordance with a new limitation. Each year beginning in 2014, O&R's contribution will be the same dollar amount as in the previous year, plus a cost of living adjustment based on the change in the Consumer Price Index (CPI).

Also, effective January 1, 2013, the Companies will adopt an Employer Group Waiver Program for Medicare eligible participants. The companies will terminate their participation in the Retiree Drug Subsidy Program effective on January 1, 2013.

As of December 2014, the Retiree Health Program has been restated to provide for: (i) the integration of the amendments not yet incorporated into the Plan Document; (ii) the full integration of the O&R Retirees; (iii) the changes required by the Mental Health Parity and Addiction Equity Act and the Patient Protection and

Affordable Care Act; (iii) changes to the subrogation provisions and other rights of recoupment and overpayment in any form, in accordance with U.S. Supreme Court holdings; and (iv) other administrative updates.

In the Retiree Health Program, each individual who is eligible and covered is referred to as a Participant. Each person who was an employee of an Employer and who is eligible and covered is referred to as a CECONY Retiree, an O&R Management Retiree, or an O&R Local 503 Retiree. Each person who is an eligible dependent of a CECONY Retiree, an O&R Management Retiree, or an O&R Local 503 Retiree is referred to as a Covered Eligible Dependent.

ARTICLE I

Definitions

When used herein, the following terms shall have the meaning set forth below, unless the context otherwise requires:

1.01 Annual Deductible

means the amount a Participant, including an O&R Management Retiree, must pay in each Plan Year before the Program will begin paying benefits in that Plan Year. The Program may have a separate inpatient stay/hospital deductible ("Inpatient or hospital Deductible"), medical deductible ("Medical Deductible"), and prescription drug plan deductible ("Drug Deductible").

CECONY or O&R, as applicable, each has the right to change, introduce, increase, or otherwise modify the kinds and amount of Annual Deductibles. O&R establishes the Annual Deductibles for O&R Local 503 Retirees, subject to applicable relevant collective bargaining agreements.

1.02 Benefit Period

means all or a part of the Plan Year.

1.03 Board

means the Board of Directors of CEI.

1.04 Board of Directors

means the Board of Directors of O&R.

1.05 Board of Trustees

means the Board of Trustees of CECONY.

1.06 Care Coordination

means the utilization review entity whose purpose is to oversee and monitor the delivery, appropriateness, and effectiveness of certain health care. Effective January 1, 2010, Cigna provides care coordination through a medical management review team.

1.07 Cash Balance Participant

means a Retiree, Participant, or Employee who was covered under the cash balance formula in the Retirement Plan and was an active employee of CECONY, O&R, or a CEI Affiliate immediately prior to termination of employment or retirement, as the case may be. Cash Balance Participant also means the Eligible Covered Dependent, Surviving Spouse, or Spouse of the Retiree, Participant, or Employee who was covered under the cash balance formula.

1.08 CECONY

means Consolidated Edison Company of New York, Inc.

1.09 CECONY Retiree

means each CECONY Employee who has met the age and service eligibility requirements, has elected, and is participating in the Retiree Health Program.

1.10 CECONY Transferred Employee

means an Employee who was employed by CECONY, participated in the Retirement Plan, and transferred directly, without a break in service, from CECONY to O&R or a CEI Affiliate.

1.11 CEI

means Consolidated Edison, Inc., its successors or assigns.

1.12 CEI Affiliates

means one, more than one, or all, as the context indicates, of those Affiliates of CEI who have adopted the Program on behalf of the CECONY Transferred Employees who are employed as employees for the Affiliate. The CEI Affiliates who are adopting employers may change from time to time; provided, however, that in no case may a company that is not a member of the controlled group of CEI, as that term is defined in the Internal Revenue Code Sections 414(b), (c), (m) or (n) be a CEI Affiliate. The applicable CEI Affiliate board must approve the adoption of the Program on behalf of the CECONY Transferred Employees.

1.13 Charge(s)

mean Charge(s) for a Covered Service in the Retiree Health Plan as follows:

a. If the expense is for a Non Eligible Medicare Retiree and provided by a Network Provider, the Charge for a Network Provider means the pre-negotiated contract rate, the contract rate, or the pre-negotiated fee, as the third party administer determines in its sole and absolute discretion.

b. If the expense is for a Medicare approved expense, the Charge is the Medicare Allowable Amount or Medicare Approved Amount, as Medicare determines in its sole and absolute discretion.

c. If the expense is for a Non Eligible Medicare Retiree and provided by a Non Network Provider, in all cases, the Charge is the lesser of an amount determined by the third party administrator calculated based on available data resources of competitive fees in that geographic area, unless services are received as a result of an Emergency or as otherwise arranged through the third party administrator. Charges are determined solely in accordance with the third party administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, solely in the discretion of the third party administrator, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies and:

i. As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
ii. As reported by generally recognized professionals or publications.
iii. As used for Medicare.
iv. As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the third party administrator accepts.

In all cases, the Charge is based on the appropriate third party administrator or Medicare and is final, binding, within their sole discretion, and applicable to all parties.

1.14 CMS

means the Committee on Medicare and Medicaid Services.

1.15 COBRA

means the health care continuation coverage law as set forth in Code Section 4980B, established by the Consolidated Omnibus Budget Reconciliation Act of 1985.

1.16 COBRA Coverage

means the health care continuation coverage a Participant may elect if she or he loses coverage under the Program on account of a "Qualifying Event," as that term is defined in and otherwise satisfies the terms and conditions set forth in Code Section 4980B.

1.17 Code

means the Internal Revenue Code of 1986, as amended, from time to time. Reference to any section or subsection of the Code includes reference to any succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

1.18 Coinsurance

means the Participant's share of the Charge of a Covered Service.

1.19 Company

means CECONY, its successors or assigns. As of 2009, if explicitly stated, Company includes O&R as it applies to O&R Participants. "Companies" mean CECONY and O&R.

1.20 Concurrent Care Claim

means a claim for ongoing treatment, covering either a period of time or a number of treatments, for which the Fiduciary has decided to terminate or reduce such previously approved benefits. The reduction or termination of the treatment has to cause disruption and potential harm to the Participant receiving the ongoing care.

1.21 Contribution

means the amount a Retiree, Surviving Spouse, Spouse, Domestic Partner, and Dependent Child must pay for coverage under the Retiree Health Plan, HMO, and Prescription Drug Plan. The Contribution represents the cost of benefits and administrative expenses. The Contribution is subject to change from time to time, and for all Participants other than O&R Local 503 Retirees, at the sole and absolute discretion of the Companies, and is designed to cover the estimated cost of claims and the administrative expenses involved in maintaining the Program.

There is a separate Contribution for the Retiree Health Plan, the HMOs, and the Prescription Drug Plan.

1.22 Co-payment

means the amount a Participant must pay to a Network Provider at the time services are given. Co-payments are not counted toward any Deductible or Out-of-Pocket Limits.

1.23 Covered Dependent

means a Dependent who is a Participant.

1.24 Covered Service

means the medical, hospital, vision care and prescription drug benefits covered under the Program. Covered Services may change from time to time, solely in the discretion of the Company or the Plan Administrator, as applicable. Covered Services may be determined by the fiduciary or the third party administrator or health care insurer.

Covered Service means health services, supplies and treatments provided for the purpose of preventing, diagnosing or treating an accidental injury, sickness, mental illness, drug abuse or their symptoms. A Covered Service is one that is not specifically excluded, Experimental, Unproven or Investigational. Covered Services are included only when the person receiving the service meets all eligibility requirements including, if necessary, notification requirements. Covered Services, in general, does not include care that is cosmetic or promotes and is primarily a life –style service.

1.25 Custodial Care

means, subject to the determination of the Claims Fiduciary, services that:

a. are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or

b. are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or

c. do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

1.26 Dependent

means a Retiree's Spouse, Domestic Partner or Dependent Child. Effective January 1, 2013, Dependent does not mean Domestic Partner; provided, however, effective January 1, 2015, Dependent does not mean an O&R Hourly Retiree's Domestic Partner.

1.27 Dependent Child

means an unmarried dependent child of a Retiree up to the end of the calendar year in which the unmarried dependent child attains age 19.

If the Dependent Child is a full-time student, he or she continues to be a Dependent Child until the earliest of the end of the month in which he or she: gets married, is no longer a dependent of the Retiree, or attains age 23.

A Dependent Child includes a child by birth, legally adopted, or placed for adoption in anticipation of being legally adopted, or a stepchild living in the household of the Retiree or Surviving Spouse who serves as that child's legal guardian. A Dependent Child includes a child who is disabled, regardless of age, if he or she becomes or became physically or mentally disabled and incapable of self-support before age 19 or while covered under the Program.

Effective for Plan Years beginning before January 1, 2003, a foster child of a Retiree is eligible to be a Dependent Child. Beginning on and after January 1, 2003, a foster child is not an eligible Dependent Child.

A Dependent Child is a child who meets the requirements to be a "dependent child," as set forth in the paragraph supra, is not regularly employed on a full time basis and is fully dependent on the Retiree or Surviving Spouse for financial support.

A child under the age of 19 who is regularly employed on a full time basis and is not fully dependent on the Retiree or Surviving Spouse for financial support is not a Dependent Child.

The Companies require initial proof of each child's dependent status before approving coverage. The Companies reserve the right, at its discretion, to request subsequent proof of dependent status at any time and for any reason.

1.28 Disability or Disabled

means "Disability" or "Disabled," as the case may be, as that term is defined and determined in the Retirement Plan; provided, however, that the Plan Administrator has the full and absolute discretion to determine whether a Retiree is suffering from a Disability. A determination by the Social Security Administration of disability is not determinative or binding on the Plan Administrator. The Plan Administrator may delegate to another fiduciary the authority to exercise its full and absolute discretion to determine whether a Dependent Child is Disabled. In all cases, the Fiduciary is not required to rely on the individual's treating doctor to make the final determination as to whether the individual is Disabled.

1.29 Effective Date of the Program

means January 1, 1986. The Effective Date of this restated Retiree Health Plan is January 2013.

1.30 Eligibility Date

means the date a Retiree must enroll in a Plan.

1.31 Emergency Care

means medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in the patient's health being placed in serious jeopardy, or a bodily function would be seriously impaired, or there would be a serious dysfunction of a bodily organ or part.

1.32 Employee

means an individual who is employed by and a common law employee of a Company or an Employer. An Employee does not mean a person who is a temporary employee or a leased employee, as defined in Code Section 414(n).

1.33 Employer

means CECONY, O&R and each CEI Affiliate who, with the approval of CECONY, becomes an Employer upon adoption of the Program.

1.34 Employer Group Waiver Plan (EGWP)

means an Employer Group Waiver Plan as described in and regulated by 42 CFR Parts 417, 422, and 423 of the MMA.

1.35 ERISA

means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.36 Experimental, Investigational, or Unproven Service

means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Fiduciary makes a determination regarding coverage in a particular case, are determined to be any of the following:

a. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American hospital Formulary Service or the United States

Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

b. subject to review and approval by any institutional review board for the proposed use; or

c. the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

d. not of proven benefit for either the particular diagnosis or treatment of the covered person's condition; or

e. not generally recognized by the medical community as effective for the particular diagnosis or treatment of the covered person's particular condition. Government approval of a technology is not necessarily sufficient to render it a proven benefit nor appropriate or effective for a particular diagnosis or treatment of a covered person's particular condition; or

f. a service that does not meet the definition of a covered health service.

Unproven services are those that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either well –conducted randomized controlled trials or well –conducted cohort studies. Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well –conducted randomized trials or cohort studies.

1.37 Fiduciary

means the person, entity or organization that has discretionary authority and control over a part of the administration and operation of the Program. There are several Fiduciaries in charge of the operation and administration of the Program and Fiduciaries who make claim decisions ("Claims Fiduciary") the authority of which to make decisions are final and binding on all parties. If any decision or determination of a Fiduciary is challenged by a court with jurisdiction, the determination will be reviewed on an arbitrary and capricious standard.

Effective August 1, 2003, United Healthcare is the Claims Fiduciary for the Retiree Health Plan and Caremark is the Claims Fiduciary for the Prescription Drug Plan. Effective January 1, 2010, CIGNA is the Claims Fiduciary for the Retiree Health Plan.

1.38 Government Plan

means any health plan or coverage, other than Medicare or Medicaid, which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

1.39 Group

means each of the following Groups: the CECONY Retiree, the O&R Management Retiree, or the O&R Local 503 Retiree.

1.40 HMO

means a health maintenance organization that has agreed to provide coverage to those Retirees who elect coverage under the HMO option. An O&R Participant is not eligible to elect an HMO.

1.41 Injury

means accidental bodily damage other than Sickness, including all related conditions and recurrent symptoms.

1.42 Investment Manager

means an investment manager as defined in Section 3(38) of ERISA.

1.43 Lifetime Maximum

means the total amount the Retiree Health Program will pay or provide for Covered Services. A Covered Service also may have its individual Lifetime Maximum.

For each CECONY Retiree, in the aggregate and beginning on her or his first day of participation and ending on her or his date of death, the Retiree Health Program has a Lifetime Maximum of one million dollars, for the payment of all Covered Services payable under the Program including Inpatient and/or hospital Stays, major medical benefits, vision care, and prescription drug benefits. Included within the Lifetime Maximum is also the Companies' share of the cost of coverage under an HMO.

If the O&R Retiree is under age 65, in the aggregate and beginning on her or his first day of participation and ending at the end of the month in which he or she turns age 65, his or her Lifetime Maximum is one million dollars. Upon attainment of age 65, his or her Lifetime Maximum is $35,000.

1.44 MMA

means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that added a new prescription drug program to Medicare (Part D of Title XVIII of the Social Security Act (Act), referred to here as "Part D" of Medicare.) Prescription drug coverage under Medicare became available starting January 1, 2006.

1.45 Master Health Plan

means the Consolidated Edison, Inc. Master Health Plan for Eligible Employees of Consolidated Edison Company of New York, Inc., Orange and Rockland Utilities, Inc. and Certain Affiliates of Consolidated Edison, Inc., as effective January 2003.

1.46 Medical Expert

means a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Medical Expert cannot be the same person involved in or consulted with in connection with the initial adverse benefits claim determination. The Medical Expert cannot be the subordinate of the Fiduciary who is making the applicable determination.

1.47 Medicare

means, solely for the Program, and effective January 1, 2006, Medicare Part A and Part B, but not Medicare Part D, unless the context clearly provides otherwise.

1.48 Medicare Eligible Participant

means a Participant who is eligible for, whether or not enrolled in, Medicare.

1.49 Medicare Part D

means, effective January 1, 2006, Medicare Part D, as passed by the MMA.

1.50 Named Fiduciary

means, for the purpose of the administration and operation of the Program, the Vice President – Human Resources of CECONY. For the purpose of the asset management and investment obligations of the Retiree Health VEBAs, the Named Fiduciaries are the Chief Executive Officer, the Chief Financial Officer, and the Chief Accounting Officer of CECONY.

Effective as of February 15, 2012, the number of persons serving as Named Fiduciaries has been increased from three to five members (hereinafter the Named Fiduciary Committee).

Effective as of February 15, 2012, the Chief Executive Officer has been removed, by title, as a Named Fiduciary and has been replaced, by title, by the Vice President – Human Resources. Also, the Board of Trustees, at the February 15, 2012, meeting has authorized the Chief Executive Officer, in his or her capacity, to appoint two other individuals to the Named Fiduciary Committee.

1.51 Network

means the group of health care providers established, maintained and overseen by and in contract with the applicable Plan Administrator to participate in a Network.

1.52 Network Provider

means a health care provider who is in the Network.

1.53 Non Medicare Eligible Participant

means a Participant who is not eligible for Medicare.

1.54 Non Network Provider

means a health care provider who is not in the Network.

1.55 O&R

means Orange and Rockland Utilities, Inc.

1.56 O&R Local 503 Retiree

means an Employee of O&R who was on the active hourly payroll of O&R and eligible for and elected to participate in the Program.

1.57 O&R Management Retiree

means an Employee of O&R who was on the active management payroll of O&R and eligible for and elected to participate in the Program.

1.58 O&R Retiree

means an O&R Local 503 Retiree and O&R Management Retiree and each of his/her eligible Dependent who is covered by and participates in the Program.

1.59 Part B Expenses

means medical expenses covered by Medicare Part B. In general, based on the 2013 Medicare rules, Part B Expenses include coverage for services or supplies that are needed to diagnose or treat a medical condition and that meet accepted standards of medical practice. Part B Expenses may also include health care to prevent illness or detect it at an early stage, when treatment is most likely to work best.

The amount that a Medicare Eligible Participant pays, if any, for a Part B Expense is based on the Medicare Rules and whether treatment is receiver by a health care provider who accepts assignment. Assignment means that there is an agreement between Medicare and a doctor or health care provider to be paid directly by Medicare, to accept the payment amount Medicare approves for the care, and not to bill the Medicare Eligible Participant for any more other than the Medicare deductible and coinsurance..

1.60 Participant

means a Retiree, a Surviving Spouse, a Spouse, and/or a Dependent Child, who is participating in the Program.

1.61 Pension

means the monthly benefit payable to a CECONY Participant or a CEI Participant who has satisfied the requirements in the Retirement Plan for a "rule of 75 point" pension. Pension does not mean the monthly pension allowance payable under the Retirement Plan to a person who has not satisfied the age and service requirements for a Rule of 75 Pension and does not include a "cash out" or single sum payment from the Retirement Plan.

Pension for an O&R Retiree means the monthly benefit payable for satisfying the requirements for an early retirement pension.

1.62 Plan Administrator

means the Vice President-Human Resources of CECONY or such other person designated by CECONY to serve as the Plan Administrator. The Plan Administrator is a Named Fiduciary.

1.63 Plan Year

means the calendar year.

1.64 Post-service Claim

means a claim for payment of medical care that has already been rendered.

1.65 Prescription Benefit Manager (PBM)

means, for purposes of claims related to the prescription drug plan, Caremark or the person or entity otherwise designated by the Named Fiduciary or Plan Administrator to serve as the claims administrator whenever a claim for prescription benefits is involved. PBM means an entity that has, as its principal focus, the implementation of one or more device and/or prescription drug benefit programs and which generally includes pharmacists, typically provide claims processing services for devices and/or prescription drugs; negotiate device and/or prescription drug prices; negotiate volume purchase agreements with medical device and/or pharmaceutical manufacturers, develop formularies, and institute formulary compliance programs (e.g., mandatory generic substitution programs).

1.66 Pre-service Claim

means a claim in which prior approval is needed before the claim will be covered in whole or in part. A Pre-service Claim includes a request for preauthorization to obtain receiving a larger benefit of the expenses.

1.67 Qualified Beneficiary

means a Participant who has a Qualifying Event. A Qualifying Event is only relevant for purposes of determining whether someone may be entitled to COBRA.

1.68 Qualifying Event

means one of the following events and is relevant for purposes of determining only whether someone is eligible for COBRA. Qualifying Event in the Retiree Plan is not the same as an Change of Life Status in the Master Health Plan and does not otherwise permit an Covered Participant to make a change in coverage.

a. death of the Retiree or Surviving Spouse;

b. divorce, marriage, annulment or legal separation of the Retiree or Surviving Spouse;

c. loss of dependency status;

d. change in number of dependents, including birth, adoption, placement for adoption, and death of dependent;

e. change in employment status (termination or commencement of employment) for covered Spouse or Dependent

f. change in work schedule, including a reduction or increase in hours of employment for covered Spouse or Dependent, a switch between part-time and full-time status, a strike or lockout, and beginning or returning from an unpaid leave of absence

g. enrollment in Medicare or Medicaid

1.69 Reasonable and Customary Charge, Maximum Reimbursable Amount, Medicare Allowable Amount, and/or Pre-negotiated Rate or Contract Amount

mean a Charge or Charges for a Covered Service in the Retiree Health Program.

1.70 Recovery

means monies paid to or on behalf of the Participant by way of a judgment, settlement, or otherwise, to compensate for all losses caused by, or in connection with, injuries or illness sustained by the Participant.

1.71 Rehabilitative Care

is care needed to restore normal living – that is, the ability to perform the usual activities of daily living such as bathing, dressing and preparing meals. This care may consist of physical, occupational, speech or hearing therapy and rehabilitative counseling.

1.72 Reimbursement

means repayment to the Program for medical or other benefits that it has paid towards the care and treatment of an injury, sickness or illness. Reimbursement includes expenses incurred by the Program in collecting this benefit amount.

1.73 Retiree

means an Employee who, on the date immediately prior to termination of employment with an Employer, was: (a) on the active payroll of CECONY, O&R, or a CEI Affiliate that is a participating Employer; (b) actively participating in the Master Health Plan or, if not, he or she had, without any break in coverage, minimum essential coverage as defined in Section 5000A(f)(1) of the Code; and (c) a participant in the Retirement Plan entitled to a Pension Allowance. An individual who terminates employment and has not satisfied the eligibility requirements at the time of termination does not "grow into" eligibility.

1.74 Retiree Health Plan

means the medical plan offered under the Program. In the case of an individual not eligible for Medicare, the Retiree Health Plan is the Open Access Plan, as currently referred to by the third party administrator. In the case of an individual eligible for Medicare, the Retiree Health Plan is the Medicare Supplemental Plan.

1.75 Retirement Plan

means the Consolidated Edison Retirement Plan, as amended from time to time.

1.76 Sickness

means physical or mental illness, disease or Pregnancy.

1.77 Spouse

means the person who is lawfully married to, not separated from, and shares and is living in the same residence as the Retiree.

1.78 Surviving Spouse

means the same Spouse who was lawfully married to, not separated from and shared the same residence of the Retiree on the date the Retiree's Pension began payment and the date of death of the Retiree. A Surviving Spouse must be receiving a surviving spouse's pension benefit from the Retirement Plan. A Domestic Partner is not considered a Surviving Spouse. A Surviving Spouse must either be already covered by the Program or have other group coverage (other than Medicare or Medicaid) at the time of the Retiree's death.

1.79 Subrogation

means the right of the Program to pursue the Participant's claims for medical or other charges paid by the Program against the other person, the other person's insurer and/or any other third party.

1.80 Third Party Administrator

means Caremark for the Prescription Drug Plan and, effective January 1, 2010, CIGNA for the Retiree Health Plan.

1.81 Trust Agreement

means one or more of the trust agreements, as amended from time to time, between the Trustee and the Companies under which the Trustee holds the Trust Funds.

1.82 Trustee

means the trustee at any time appointed by the Board, Board of Trustees, Board of Directors or Named Fiduciaries and acting as trustee of one of the Trust Funds. As of January 1, 2003, State Street Bank and Trust Company serves as the Trustee.

1.83 Trust Funds

mean one or more of the trust funds described in Article VI hereof.

1.84 Urgent Care Claim

means a claim for medical care that is needed quickly to avoid seriously jeopardizing the life or health of the Participant. An Urgent Care Claim is also a claim where the health care provider determines that the Retiree is in severe pain. If the health care provider determines the claim is urgent, the Program must treat the claim as urgent.

1.85 VEBA

means a voluntary employee beneficiary association, as that term is defined in Code Section 501(c)(9) and the regulations promulgated by the Treasury regarding Code Section 501 (c)(9).

1.86 Year of Service

means a Year of Service as defined in and determined by the terms and conditions in the Retirement Plan.

ARTICLE II

Eligibility and Eligibility Date

2.01 Eligibility

Only the following persons are eligible to participate in the Program:

a. **CECONY Retiree –** A Retiree who is a CECONY Employee or employed by a CEI Affiliate is eligible to elect to participate if, and only if, on the date immediately prior to termination of employment from CECONY or a CEI Affiliate, he or she was actively employed and:

i. attained an age that, when added to his or her Years of Accredited Service, total at least 75 Points and becomes eligible for a Pension; or terminated employment on account and because of a total and permanent Disability, as determined at the discretion of the Plan Administrator, and at the time of termination of active employment, attained at least age 50 and had at least 20 Years of Accredited Service; and

ii. was actively participating in the Master Health Plan, or had coverage under another employer group health plan, or had minimum essential coverage, as defined by Section 5000A(f)(1) of the Code under a platinum level plan and, in all instances, had no break in coverage; and

iii. was eligible to immediately elect to begin a distribution of his or her Pension.

b. **O&R Retiree –** A Retiree who is an O&R Employee is eligible to elect to participate if, and only if, on the date immediately prior to termination of employment, he or she was actively employed, attained age 55 and has ten years of eligible service. Eligible service is further defined and based on eligibility for early retirement under the Consolidated Edison Retirement Plan. Effective on January 1, 2015, each O&R Local 503 Employee must have attained age 55 and have twenty years of eligible service.

c. **Spouse.**

i. If a Spouse is an Employee and covered under the Master Health Plan, he or she cannot be covered concurrently under the Program.

ii. A Spouse, who is not a Surviving Spouse, is not eligible to continue participation upon the death of the Retiree.

iii. If a Retiree discontinues participation for any reason, his or her Spouse is no longer eligible for coverage.

iv. Effective before January 1, 2015, for a Local 503 O&R Retiree, a Domestic Partner, in general, is treated as a Spouse but is not eligible to be a Surviving Spouse.

v. Spouse does not include a legally separated or divorced spouse, even if the separation agreement or divorce decree states that coverage must be provided. If the court orders a Retiree to provide coverage for a legally separated or divorced spouse, the Retiree must arrange coverage on his or her own.

vi. The difference between a Spouse and a Surviving Spouse is that a Spouse became a Spouse only after the Retiree began his or her Pension and only after he or she became covered under the Retiree Plan. He or she is considered a newly acquired dependent. In general, the Retiree must provide notice within 30 days of his or her marriage if the Retiree seeks to cover his or her new Spouse.

d. Surviving Spouse.

i. A Surviving Spouse may continue to participate in the Program following the death of the Retiree.

ii. If a Surviving Spouse is an Employee and covered under the Consolidated Edison Master Health Plan, he or she cannot be covered under the Program.

iii. The spouse of a Surviving Spouse is not eligible to participate.

iv. If a Surviving Spouse acquires a dependent child who was not the eligible dependent child of the Retiree, that child is not eligible to participate.

e. Dependent Child. Special Rules:

i. A Dependent Child is eligible to participate until the earlier of his or her loss of dependency status or the death of the last living of the Retiree and/or Surviving Spouse; provided, however, that the Dependent Child is the child of the Retiree.

ii. A child acquired by a Surviving Spouse or Spouse following the death of the Retiree is not eligible to participate.

iii. An unmarried disabled Dependent Child is eligible regardless of age if the child becomes physically or mentally incapable of self-support either before age 19 or while he or she is a participant in the Program. Coverage ends upon the earlier of the date of death of the last living of the Retiree or Surviving Spouse or the death the child is no longer Disabled.

iv. A child is considered a full-time student if he or she is enrolled in at least nine hours of a regular curriculum that leads to a diploma or degree at an accredited high school, technical college, or university. A full-time student that takes a medical leave of absence from college may continue coverage for up to 12 months if he or she does not otherwise qualify as a disabled dependent. A temporary reduction in credit hours after the semester starts does not result in a change in status, unless the child no longer is enrolled in a qualified program. A child is considered a full-time student during semester breaks if he or she was enrolled the prior semester, unless the child secures a full-time permanent job, gets married, or does not enroll when school resumes. If an eligible dependent child who is age 19 to 23 and who qualified for full-time student eligibility is no longer eligible due to graduation, his or her coverage will end on the date of the event

v. If an eligible dependent child is no longer eligible due to marriage or a full-time job that offers benefits coverage, his or her coverage will end on the date of the event.

vi. The Companies reserve the right to ask for proof of full-time student eligibility. Failure to comply with this provision will result in loss of coverage for the dependent and may result in financial repercussions for the Retiree. If an eligible dependent child who qualified for full-time student eligibility is no longer eligible for participation because he or she turns age 23, his or her coverage will end on the date of the event.

2.02 Eligibility Date

a. In general, each Retiree's Eligibility Date is the day she or he terminates or retires from employment and is eligible to elect to receive an immediate distribution of his or her pension and has satisfied the

requirements to participate. The first date of coverage is the first day of the month immediately following the Retiree's Eligibility Date. This is the case even if an immediate distribution of a pension is discounted to take into account an early distribution date.

b. Upon first becoming eligible to participate, each Retiree or Surviving Spouse will notify or be notified by the Plan Administrator of his or her eligibility. Failure to be notified by the Plan Administrator does not result in an extension of the person's otherwise applicable eligibility date.

c. A Retiree, Surviving Spouse, and any other Eligible Dependent must elect to participate by completing and signing enrollment forms provided by the Plan Administrator no later than 30 days after the earliest day that he or she may commence participation; this is his or her Eligibility Date. If available, enrollment may be completed online or by a telecommunications program. Failure to elect coverage during this 30-day period – his or her Eligibility Date – results in a total and permanent forfeiture of eligibility to participate in the future; provided, however, that if he or she has other acceptable health coverage as specified below and no break or gap in coverage, his or her Eligibility Date may be extended so long as the affected individual complies with any administrative notice requirements.

d. A Surviving Spouse of a Retiree, which Retiree was eligible but died before becoming a Participant, has 60 days following the death of the Retiree to elect to participate.

e. Effective January 1, 1999, a CECONY Retiree, who at time of termination of employment has at least 75 points and elects to defer commencement of his or her Pension, may elect to participate in the Program immediately following termination of employment. Effective for the Plan Years beginning before December 31, 1998, a Retiree, who at time of termination of employment had at least 75 points, had to elect commencement of his or her Pension immediately following termination of employment to be eligible to participate in the Program.

f. A Retiree, Spouse, Dependent or a Surviving Spouse, who is a participant in another employer's group health plan or program sponsored by any source other than the Companies (other than an individual policy), may delay commencement of participation in the Program until expiration of the other coverage. If coverage under the Program is delayed, in order to be eligible to enroll in the Program

following the delay, he or she must provide satisfactory evidence of the other group coverage and the date the other coverage expired. Medicare or Medicaid does not qualify as a group health plan. Coverage without interruption from the first date the Retiree, Spouse, Dependent or Surviving Spouse became eligible for coverage and the date such person elects to commence coverage is required.

g. To become covered under the prescription drug benefit coverage, the Retiree or Surviving Spouse must enroll within 30 days of eligibility.

h. Unless a Retiree or Surviving Spouse or other Eligible Dependent has other group health coverage on his or her Eligibility Date, failure to elect to participate on his or her Eligibility Date results in the permanent loss of eligibility to participate in the future.

i. The intent of these rules is to avoid permitting any individual to have a gap in meaningful, minimum essential health care coverage and then, subsequently, request coverage under the Plan.

2.03 <u>Special Eligibility Rules for Medicare Part D Eligible Participants</u>

a. Effective for Plan Year 2006, a CECONY Retiree who is a Medicare Eligible Participant annually may elect to participate in the Prescription Drug Plan, may elect Medicare Part D for prescription drug coverage or may elect no drug plan. If the Medicare Eligible Participant elects Medicare Part D, there will be no coverage under the Prescription Drug Plan for each year in which the Participant elects Medicare Part D. There is no coordination of benefits between the Prescription Drug Plan and Medicare Part D.

b. A CECONY Retiree Medicare Eligible Participant, once a year and during open enrollment, may choose between Medicare Part D and the Prescription Drug Plan. Enrollment in Medicare Part D is treated as other group coverage solely for purposes of the Prescription Drug Plan. A Medicare Eligible Participant who has none or elects no prescription drug coverage under the Prescription Drug Plan, Medicare Part D or any other group coverage, will not be eligible in the future to re-enroll in the Prescription Drug Plan.

c. Effective January 1, 2013, the Companies have elected to discontinue their participation in the Retiree Drug Subsidy Program and have elected to participate in an Employer Group Waiver Program. Consequently, effective January 1, 2013, a CECONY Retiree who is a

Medicare Eligible Participant may elect to participate in the EGWP or elect no coverage. If a CECONY Retiree who is a Medicare Eligible Participant is enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, he or she may not enroll in the EGWP unless he or she disenrolls from the HMO, PPO or MA PFFS plan.

ARTICLE III

Summary of Retiree Health Program And Participant's Costs

3.01 Retiree Health Program Summary of Covered Services

In general, the Program pays all or a portion of the Charges for a Covered Service. Coverage is available only if all of the following are true:

a. The Covered Service is received while the Program is in effect.

b. The Covered Service is received prior to the date that coverage ends for the individual.

c. The person who receives the Covered Service is a covered Participant and meets all eligibility requirements specified in the Plan.

3.02 Organization of Retiree Health Program

The Retiree Health Program covers Non Medicare Eligible Participants and Medicare Eligible Participants. The Retiree Health Program offers a network and non-network provider plan for a Non Medicare Eligible Participant (the Retiree Health Plan) and for an O&R Retiree who is under age 65 and Medicare eligible and a Medicare Supplemental Plan for each Medicare Eligible Participant notwithstanding the O&R Retiree who is under age 65.

A Prescription Drug Plan is available for each Non Medicare Eligible Participant and a Medicare Part D Plan is available for each Medicare Eligible Participant.

a. Each CECONY Retiree or his or her Covered Eligible Dependent who is a Non Medicare Eligible Participant may elect to participate in the Retiree Health Plan or an HMO.

b. Each O&R Retiree or his or her Covered Eligible Dependent who is a Non Medicare Eligible Participant or who is under age 65 and a Medicare Eligible Participant may elect to participate only in the Retiree Health Plan.

c. Each CECONY Retiree or his or her Covered Eligible Dependent who is a Medicare Eligible Participant may elect to participate in the Medicare Supplemental Plan or an HMO.

d. O&R Retiree or his or her Covered Eligible Dependent who is a Medicare Eligible Participant and has attained age 65 may elect to participate only in the Medicare Supplemental Plan.

3.03 Participant's Costs

In general, each Participant is responsible for payment of one or more of the following, as applicable: Contributions, Deductibles, Co-payments, Out-of-Pocket Limits, and the Co-insurance. Each Company determines the amount or percent of each of the costs borne by the Participants. There are also Lifetime Maximums applied to each CECONY Retiree and each O&R Retiree.

3.04 Cash Balance Participants' Costs

Effective January 1, 2013, CECONY, O&R, and each CEI Affiliate will not contribute towards the cost of coverage for a Cash Balance Participant. Each Cash Balance Participant is responsible for the total cost of his or her individual or family premium (also referred to as Contribution), as the case may be.

However, if a Cash Balance Participant had retired prior to January 1, 2013, and commenced participation in the Retiree Health Program immediately following termination or retirement ("Pre 2013 Cash Balance Participant"), such Pre 2013 Cash Balance Participant will pay the same cost for coverage that he or she would pay if he or she were a CECONY Participant or an O&R Participant, as the case may be, and subject to whatever changes in cost occur for the applicable CECONY Participant or O&R Participant.

Additionally, the amount that O&R will contribute towards the cost for an O&R Local 503 Retiree and the amount of the cost that the O&R Local 503 Retiree will pay for the cost of coverage is determined based on collective bargaining agreements, as applicable.

3.05 Defined Contribution Pension Formula Participants' Costs

Effective January 1, 2013, CECONY, O&R, and each CEI Affiliate will not contribute towards the cost of coverage for a Defined Contribution Pension Formula Participant; subject to the obligation of O&R for a Local 503 Retiree. Each Defined Contribution Pension Formula Participant is responsible for the total cost of his or her individual or family premium (also referred to as Contribution), as the case may be.

3.06 Deductibles

a. Inpatient Admission Deductible

The annual inpatient Deductible for an inpatient admission in a hospital, skilled nursing facility, hospice, inpatient rehabilitative care facility, and/or inpatient care for mental health disorders,

is 50% of the Medicare Part A deductible. The inpatient Deductible changes whenever the Medicare Part A deductible changes and whenever else the Company or an Employer determines, in its sole discretion. Each Participant is subject to the inpatient Deductible.

The inpatient Deductible is on a per-person/per-year basis. The inpatient Deductible applies to all inpatient stays with a Network Provider and a Non Network Provider, and applies to each Participant regardless of age or Medicare eligibility.

The Inpatient Deductible for an O&R Local 503 Retiree is set forth in Attachment A.

b. Medical Deductible

A deductible is required for most medical benefits. If a Participant uses a Network Provider in the Retiree Health Plan; however, he or she may not be required to pay a Medical Deductible.

c. Prescription Drug Plan Deductible

A per person per year deductible generally is separate from the deductible for inpatient admissions or the medical deductible and generally required for all prescription drugs.

3.07 Co- payments and Co- insurance

a. Network Provider. A Non Medicare Eligible Participant who uses a Network Provider will be required to pay a Co-payment for most Covered Services.

b. Non-network Provider. After a Participant meets the applicable annual Deductible, if required and applicable, the Retiree Health Plan will pay a percent of the Charge for most Covered Services. The Participant pays the remaining percent. The applicable percent is subject to change from time to time at the sole and absolute discretion of the Company or each Employer.

c. Out-of-Pocket Maximum. After a Participant pays the Out-of-Pocket Maximum, the Retiree Health Plan pays 100% of the Charges for the Covered Service during that year up to the Lifetime Limit.

d. The lifetime limit for a CECONY Retiree or his or her Covered Eligible Dependent is one million dollars and includes the Program's payments for vision care, hospitalization and inpatient stays, network providers and Medicare. The lifetime limit for a CECONY Retiree or his or her Covered Eligible Dependent begins on the first date the individual is covered under the Retiree Health Program and ends as of his or her date of death.

e. The one million dollar lifetime limit for an O&R Retiree begins on the first date the individual is covered under the Retiree Health Plan and ends as of the last day of the month in which he or she attains age 65. Beginning on the first day of the month following the month in which he or she attains age 65 and ending on his or her date of death, he or she has a $35,000.00 lifetime limit.

f. Some expenses that are not counted toward the Out-of-Pocket Maximum include:

i. charges you incur in excess of the Charges,
ii. payments for services not covered, including those that are not necessary,
iii. surcharges,
iv. charges incurred in excess of any other limits,
v. any office visit co-payment, and
vi. monthly contributions for participation in the Retiree Health Plan and Medicare Part B premiums.

ARTICLE IV

Retiree Health Plan

4.01 The Retiree Health Plan: In General

The Retiree Health Plan is a plan within the Program offering Network Providers and Non-network Providers for hospitalization, major medical, and limited vision care. Each CECONY Retiree may choose the Retiree Health Plan or an HMO. An O&R Retiree may not choose an HMO option. An HMO offers benefits similar to the Retiree Health Plan as well as some preventive services and prescription drugs.

If a CECONY Retiree or his or her Covered Eligible Dependent chooses the Retiree Health Plan, prescription drugs are offered in a separate Prescription Drug Plan that is separately elected. If an O&R Retiree or his or her Covered Eligible Dependent chooses the Retiree Health Plan, he or she is automatically covered under the Prescription Drug Plan.

The Medicare Supplemental Plan coordinates benefits with Medicare Part A and Part B for a Medicare Eligible Participant and offsets Medicare-approved Charges within the reimbursement of Medicare.

The Retiree Health Plan and the Prescription Drug Plan will not coordinate benefits with Medicare Part D. A Participant who enrolls in Medicare Part D will not be eligible to participate in or entitled to any benefits under the Prescription Drug Plan. If the Medicare Eligible Participant elects Medicare Part D, he or she will receive her or his prescription drug coverage exclusively from Medicare Part D with no prescription drug coverage from the Prescription Drug Plan whatsoever.

4.02 Inpatient Stays: Covered Services

a. Hospital, Skilled Nursing Facility, or Other Health Care Facility

Benefits are available for Covered Services received during the inpatient stay in a hospital, skilled nursing facility, rehabilitative hospital, or sub-acute facility. Room and board is provided in a semi-private room (a room with two or more beds).

i. After meeting the annual inpatient Deductible, the Retiree Health Plan pays a percent of the Charges for a semi-private room, board and care in a hospital, skilled nursing facility, or other health care facilities.

ii. There are some limited inpatient Covered Services that are covered in full and do not require the payment of a deductible.

iii. A Non-Medicare-Eligible Participant who anticipates an inpatient stay or experiences an emergency stay must notify Care Coordination. A Medicare-Eligible Participant need not call Care Coordination because Medicare coordinates and administers the inpatient stays.

b. Separate and Related Hospital Visits

i. Benefits for hospital, skilled nursing facilities, or other health care facilities are limited to a certain number of days per person per diagnosis.

ii. Separate stays due to the same or a related diagnosis are considered related stays unless the Participant has been out of the hospital or skilled nursing facility for 90 consecutive days between the stays. During a period of related stays per diagnosis, the Participant is required to meet only one inpatient deductible without regard to whether the period runs from one calendar year to the next.

iii. Once related stays total the limit for such inpatient admission, benefits are no longer available for inpatient care for that diagnosis. Coverage applies for a hospitalization for another condition. Coverage applies if there is another admission after being out of the hospital for 90 consecutive days.

iv. If all hospital benefits are exhausted for one condition, benefits for that same condition may be eligible for continued care in another health care facility .

c. Covered Hospital Services

i. In addition to room and board, Covered Services include Charges for general nursing, special care units, drugs and anesthetics, laboratory tests, diagnostic X-rays, medical supplies, operating and recovery room, and rehabilitation services.

ii. Covered Services for an inpatient stay for pregnancy are at least: 48 hours for the mother and newborn child following a normal vaginal delivery and 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Care Coordination must be notified as soon as

reasonably possible if the inpatient stay for the mother and/or the newborn will be more than the time frames described.

iii. Without notification to Care Coordination that the inpatient stay will be extended, Benefits for the extended stay will be reduced.

d. Covered Services at Network Provider May Have no Deductible.

Certain limited Covered Services may be covered without meeting a Deductible. The list of Covered Services is subject to change from year to year.

e. Non-Custodial Care in a Skilled Nursing Facility

i. After meeting the annual inpatient deductible, the Retiree Health Plan pays Charges for semi-private room and board for non-custodial care in a skilled nursing facility. The daily limit for Covered Services for room and board is the skilled nursing facility's standard rate for a semi-private room.

ii. To receive benefits in a skilled nursing facility, the Participant must remain under a doctor's continuous care and require both 24-hour nursing care and physical restorative services for convalescence from a disease or injury. Physical restorative services are skilled services designed to improve a patient's physical functioning impaired by disease or injury. Functions that may need to be improved through physical restorative services include walking, endurance and muscle strength.

iii. While in a skilled nursing facility, Covered Services include X-rays and laboratory work; physical, occupational or speech therapy; oxygen and other gas therapy; and other medical services and supplies.

iv. Custodial Care is not covered. Custodial care means non-skilled and non-health related care that involves assisting a person in the usual activities of daily living such as dressing, bathing and preparing meals. Custodial care is made up of services and supplies that are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment. Custodial care is care that can safely and adequately be provided by anyone who does not have the technical skills of a covered health care professional. Care that otherwise meets the condition for being custodial care is custodial care regardless of who

recommends, provides or directs the care, where the care is provided, or whether the patient or another caregiver can be or is being trained to care for himself or herself.

v. Restorative Care: In order to be eligible for coverage in a skilled nursing facility, care has to be both non-custodial and restorative. In general, care after 30 days in a skilled nursing facility becomes custodial in nature. Restorative care refers to nursing interventions that promote the patient's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and activities of daily living and prevent further impairment. A rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote patient involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff.

f. Hospice Care

i. After satisfying the annual inpatient deductible, the Retiree Health Plan pays Charges for a hospice care program for up to a Lifetime Limit of 365 days. The Doctor who recommends that the Participant enter the program must certify that the Participant is terminally ill and has no more than six months to live. Charges are paid only for services ordered by the Doctor supervising the program.

ii. The daily limit for room and board in a hospice facility is the facility's standard semi-private room rate. Care provided at a hospice facility includes pain control and other acute and chronic symptom management.

iii. Other covered hospice care charges include: part-time or intermittent nursing care by a registered nurse or a licensed practical nurse for up to eight hours in any one day; medical social services under the direction of a Doctor, including assessment of the person's social, emotional and medical needs, the person's home and family situation, identification of community resources available to that person, and assisting the person to obtain needed resources; psychological and dietary counseling; consultation or case management services by a Doctor; physical and occupational therapy; part-time or intermittent home health aide services for up to eight hours in any one day; and medical supplies, drugs and medicines prescribed by a Doctor.

g. Inpatient Rehabilitative Care

i. After satisfying the annual inpatient deductible, the Retiree Health Plan pays Charges for inpatient rehabilitative care for up to 100 days in a calendar year.

ii. Rehabilitative care is care needed to restore the Participant to his or her level of normal living - that is, the ability to perform the usual activities of daily living such as bathing, dressing and preparing meals. This care may consist of physical, occupational, speech or hearing therapy and rehabilitative counseling.

iii. Care may be provided by a Hospital or an institution that is not a Hospital but is certified, licensed or approved by a federal or state agency to provide rehabilitative care.

iv. Rehabilitative care is intended to facilitate the discharge of the Participant to his or her home or an independent living situation.

h. Home Health Care

i. After satisfying the annual inpatient deductible, the Retiree Health Plan pays Charges for up to 200 skilled home health care visits in a calendar year provided by a licensed and approved home health care agency.

ii. The Participant's Doctor must submit a written skilled home health care plan and provide notification through care coordination. The skilled home health care plan must certify that if the Participant did not receive the services and supplies

described in the treatment plan, it would be necessary for the Participant to be confined as an inpatient in a Hospital or Skilled Nursing Facility.

iii. Covered Services made by an approved skilled home health care agency ordered by a Doctor and provided at home include: part-time or intermittent nursing provided or supervised by a registered nurse to perform specific nursing skills such as cleaning and dressing open or infected wounds and administering intravenous solutions; part-time or intermittent services provided by a home health aide, primarily for the care of a recovering patient; physical, occupational, speech or respiratory therapy by a qualified therapist; nutrition advice provided or supervised by a registered dietician; medical supplies, drugs and laboratory services. Care Coordination will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Doctor-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Notification to Care Coordination should occur within five business days before receiving services.

iv. Each visit by a member of a home health care team - other than a home health aide - counts as one visit. Each four hours of care by a home health aide is considered one visit.

4.03 Medical Benefits: Deductibles, Coinsurance, and Copayments

In general, for a Non Medicare Eligible Participant, if treatment is provided by a Non Network provider, an annual Medical Deductible must be met and a Coinsurance must be paid for most medical benefits. The Medical Deductible and Coinsurance may differ depending upon whether the individual is a CECONY Retiree, an O&R Local 503 Retiree or an O&R Management Retiree.

A Non Medicare Eligible Participant who is treated by a Network Provider may not need to meet a medical deductible but will incur a Copayment.

Amounts exceeding the Charges are not covered and are not taking into account for any reason, including, but not limited to the annual medical deductible or Out-of-Pocket Maximum.

In general, for a Medicare Eligible Participant, Medicare determines whether a medical benefit is a Part B Expense, and if so, the allowable amount for such Part B Expense.

4.04 Medical Benefits: Covered Services

Medical benefits for a Non-Medicare Eligible Participant, as listed below, include doctor's office visits, certain procedures done in a doctor's office, laboratory and radiology services, and supplies. While the Retiree Health Plan does not cover routine health checkups, limited preventive care is covered such as cytology screenings, well baby care and mammography screenings.

Ongoing services, such as chiropractic care, are limited in duration **and** require a treatment plan that must be submitted to the Third Party Administrator for continual coverage. Medical benefits for a Medicare Eligible Participant are determined by Medicare as to what is a Part B Expense. The list below is not a list of Part B Expenses.

a. **Ambulance Services -** Emergency only local ambulance transportation by a licensed ambulance service to the nearest hospital where emergency care can be performed. Ambulance services are not provided in a non-emergency situation.

b. **Dental Services** - Dental services when all of the following are true: treatment is necessary because of accidental damage; dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry; and the dental damage is severe enough that initial contact with a Doctor or Dentist occurred within 72 hours of the accident.

i. Benefits are available only for treatment of a sound, natural tooth. The Doctor or dentist must certify that the injured tooth was a virgin or un-restored tooth, or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

ii. Dental services for final treatment to repair the damage must be both started within three months of the accident and completed within 12 months of the accident.

c. **Durable Medical Equipment** that meets all of the following criteria: (1) it must be ordered or provided by a Doctor for outpatient use, (2) it must be used for medical purposes, (3) it must not be consumable or

disposable and (4) it must not be of use to a person in the absence of a disease or disability. There is a medical deductible for all Participants when using a Non Network Provider and a medical deductible when using a Network Provider for a CECONY Retiree or his or her Covered Eligible Dependent.

i. If more than one piece of durable medical equipment can meet the person's functional needs, Benefits are available only for the most cost-effective piece of equipment.

ii. Examples of durable medical equipment include equipment to assist mobility, such as a standard wheelchair, a standard hospital-type bed, oxygen concentrator units and the rental of equipment to administer oxygen. Delivery pumps for tube feedings, and braces that stabilize an injured body part are considered durable medical equipment and are a Covered Service, including necessary adjustments to shoes to accommodate braces, and mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.

iii. A blood pressure machine/cuff/sphygmomanometer is not covered.

iv. Durable Medical Equipment are items that are able to withstand repeated use by more than one person; serve a medical purpose; are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable.

v. Durable Medical Equipment excludes bed related items (bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses including non-powered mattresses, custom mattresses and posturepedic mattresses); bath related items (bath lift, non-portable whirlpool, bathtub rails, toilet rails, raised toilet sets, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas); chairs, lifts and standing devices (computerized or gyroscope) mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized) except for hydraulic lifts if patient is two person transfer, and auto tilt chairs; fixtures to real property (ceiling lifts and wheelchair ramps); car/van modifications; air quality items (room humidifiers, vaporizers, air purifiers, and electrostatic machines); blood/injection related items, blood pressure cuffs, centrifuges, nova pens, needle-less injectors;

heat lamp, heat pad, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, Enuresis alarms, magnetic equipment, scales-baby and adult, stair gliders, elevators, saunas, any exercise equipment, and diathermy machines.

vi. Benefits are for a single unit of durable medical equipment (example one insulin pump), repair for that unit, and replacement of a type of durable medical equipment once every five calendar years.

vii. Cigna will decide if the equipment should be purchased or rented and the equipment must be purchased or rented from the vendor Cigna identifies.

viii. Preauthorization is required for any durable medical equipment that exceeds a certain dollar amount, such dollar amount subject to change from year to year and at the discretion of the Plan Administrator and the Claims Fiduciary.

d. **Maternity Services.** Benefits for pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

e. **Outpatient Treatment of Alcoholism and Substance Abuse.** The Retiree Health Plan pays the Charges for substance abuse services received on an outpatient basis in a provider's office or at an alternate facility, including substance abuse and chemical dependency evaluations and assessment, diagnosis, treatment planning, referral services, medication management, short-term individual, family and group therapeutic services (including intensive outpatient therapy), crisis intervention and psychological testing.

f. **Outpatient Treatment of Mental Health.** The plan pays the Charge for outpatient treatment of mental health disorders.

g. **Outpatient Surgery, Diagnostic and Therapeutic Services.** Covered Services include surgery and related services, lab and radiology/X-ray, mammography testing, and other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits include only the facility charge and the Charge for required services, supplies and equipment.

h. **Doctor's Office Services.** Covered Services received in a Doctor's office include treatment of a Sickness or Injury; family planning; well-baby and

well-child care; routine well woman examinations, including pap smears, pelvic examinations and mammograms.

i. **Inpatient Surgical and Medical Services.** Professional fees for surgical procedures and other medical care received in a Hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility. When these services are performed in a Doctor's office, Benefits are included under Doctor's Office Services.

j. **External Prosthetic Devices.** Prosthetic devices that replace a limb or body part including artificial limbs, artificial eyes and breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. If more than one prosthetic appliance or device can meet the functional needs, Benefits are available only for the most cost-effective prosthetic appliance or device. The prosthetic appliance or device (a) must be ordered or provided by, or under the direction of, a Physician; (b) are for a single purchase, including repairs, of a type of prosthetic appliance or device; and (c) are provided for the replacement of each type of prosthetic appliance or device once every five calendar years.

k. **Reconstructive Procedures**. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

i. Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications.

ii. Cosmetic procedures are not Covered Services. Cosmetic procedures are procedures that may improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure.

l. **Rehabilitation Services - Outpatient Therapy**. Short-term outpatient rehabilitation services for physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy, and cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in condition within two months of the start of treatment. Benefits for speech therapy are Covered Services only when the speech impediment or speech dysfunction results from Injury, stroke or a congenital anomaly. Exclusions include any type of therapy, service, or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of Network and Non Network Benefits is limited as follows- For a CECONY Retiree, the limits are 30 visits of physical therapy per calendar year; 30 visits of occupational therapy per calendar year; and 30 visits of speech therapy per calendar year. For an O&R Retiree, the limits are 60 visits of physical therapy per calendar year; 60 visits of occupational therapy per calendar year; and 60 visits of speech therapy per calendar year. For cardiac rehabilitation therapy, the limits for an O&R Retiree is 90 days per calendar year.

m. **Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy.** After satisfying the annual medical deductible, benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Network or Non Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Exclusions include any type of therapy, service or supply including, but not limited to, spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Services performed in connection with the manipulation of the spine to correct a subluxation are covered for up to an annual maximum of $500 per person. If a network provider is used, the usual Co-payment for an office visit applies and there is no deductible for the examination and spinal manipulation. There is an aggregate $500 calendar year maximum for initial examinations, spinal manipulations and other services connected with the correction of spinal subluxation.

n. **Transplantation Services.** Covered Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a designated resource network facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Service, and is not an Experimental, Investigational or Unproven Service. Care Coordination's notification is required for all transplant services.

i. Bone marrow transplants (either from the Participant or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Service. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.

ii. Heart transplants; heart/lung transplants; lung transplants; kidney transplants; kidney/pancreas transplants; liver transplants; liver/small bowel transplants; pancreas transplants; and small bowel transplants.

iii. Benefits are also available for cornea transplants that are provided by a Doctor at a Hospital. Cornea transplants to not need to be performed at a designated resource network facility in order to receive Network Benefits. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

iv. Expenses for travel, lodging and meals for the transplant recipient and a companion are available as follows: transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up; lodging and meals for the patient (while not confined) and one companion paid at a per diem rate of up to $50 for one person or up to $100 for two people; travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the designated resource network facility; and if the patient is a Covered Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

v. There is a combined overall lifetime maximum benefit of $10,000 per Participant for all transportation, lodging and meal expenses incurred by the transplant recipient and

companion(s) in connection with all transplant procedures. Care Coordination must be notified as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If not, benefits will be reduced to 50% of Covered Services.

o. Surgical treatment, bariatric surgery, of severe morbid obesity, as determined and approved by the Third Party Administrator in accordance with its guidelines.

4.05 Physical Examinations and Immunizations for a Dependent Child

The Retiree Health Plan pays a percent of the Charges for physical exams and immunizations for the Dependent Child. There is no deductible or co-payment. Routine and preventive care is covered for Dependent Children up to age 19 or if a full time student, up to age 23.

Cytology Screenings: There is no deductible and no Co-payment if a Network Provider is used for an annual cytology screening that includes a pelvic examination, collection, and preparation of a pap smear and laboratory and diagnostic services provide in connection with examining and evaluating the pap smear.

If a Covered Participant uses a Non Network Provider, the Retiree Health Plan pays 80% of Charges for an annual cytology screening for a woman age 18 and older.

4.06 Service Covered at 100% With Deductible

After satisfying the annual medical deductible, the Retiree Health Plan for a CECONY Retiree pays 100% of Charges for the use of a Network or Non Network Provider for up to a lifetime maximum of $300 per ear for the purchase and fitting of hearing aids.

For an CECONY Retire who is Non Medicare Eligible 100% after copay in Network and his or her Covered Dependent, who is under age 65, copay for Network Provider and 70%, after medical deductible, for a Non Network Provider for a hearing examination.

For an CECONY Retire who is Medicare Eligible 100% of the Charges after medical deductible for a hearing examination.

For an O&R Retiree and his or her Covered Dependent, who is under age 65, the Retiree Health Plan pays 100% of Charges for the use of a Network or Non Network Provider up to $2,800 for the purchase hearing aids.

For an O&R Retiree and his or her Covered Dependent, who is under age 65, copay for Network Provider and 80%, after medical deductible, for a Non Network Provider for a hearing examination.

4.07 Services Covered at 100%

The Retiree Health Plan pays 100% of Charges for the use of a Network Provider for surgical outpatient services performed in a Doctor's office, a hospital's outpatient department or an ambulatory surgical center; provided, however, certain copayments may apply. This includes lab and radiology/x-rays and other diagnostic tests and therapeutic treatments.

The Retiree Health Plan pays 100% of Charges for routine mammography screening for breast cancer in accordance with the following schedule:

a. On the recommendation of a Doctor, a mammogram at any age for a Covered Participant with a previous history of breast cancer or whose mother or sister have a prior history of breast cancer;

b. A single baseline mammogram for a Covered Person age 35 through 40, and

c. A mammogram once every year, or more frequently upon the recommendation of a Doctor, for a Covered Participant, age 40 and over.

4.08 Services Not Covered Under The Retiree Health Plan

a. Charges for excluded services are not taken into account towards a Participant's Deductibles or Out-of-pocket Maximum. If a service or supply is not specifically listed below, it still may not be covered. Health care services change and it is not practicable to attempt to delineate a service which may or may not be covered in the future. The following list of excluded services or supplies also is subject to change from time to time, at the discretion of the Plan Administrator and Third Party Administrator Healthcare.

i. charges for education, special education or job training whether or not given in a facility that also provides medical or psychiatric treatment,

ii. services or supplies not necessary, for the diagnosis, care or treatment of the physical or mental condition involved, even if prescribed, recommended or approved by the attending physician,

iii. services or supplies provided under law by any school, college, or institution of learning,

iv. a portion of any charges for services and supplies that the Plan Administrator or Medicare determines is in excess of reasonable and customary charges,

v. charges that are made only because coverage exists,

vi. charges that a covered individual is not legally obligated to pay,

vii. services or supplies furnished by or for the U.S. Government or any other government unless payment is legally required,

viii. charges for or in connection with speech therapy, provided; however, that this exclusion does not apply to charges for speech therapy that is expected to restore speech to an individual who has lost an existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury,

ix. services or supplies paid by any government program or law - other than Medicaid - under which a Participant is, or could be covered,

x. services or supplies paid by no-fault insurance,

xi. prescribed or non-prescribed medical supplies and disposable supplies such as ace bandages, gauze and dressings, diabetic test strips, and orthotic appliances that straighten or reshape a body part. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment,

xii. treatment of an injury arising out of, or in the course of, any employment for wage or profit, or to treat an illness covered by a workers compensation law, occupational disease law or similar legislation,

xiii. routine check-ups or annual physical examinations, immunizations, and any other services or supplies that are not necessary for medical care of an accidental injury or illness, except as previously described,

xiv. charges for or in connection with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial,

xv. charges for procedures, services, drugs and other supplies that are Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the service or treatment is considered Experimental, Investigational or Unproven,

xvi. actual or attempted impregnation or fertilization including surrogate parenting, fees or direct payment to a donor for sperm or ovum donations, or monthly fees for maintenance and/or storage of frozen embryos, diagnosis and treatment of infertility when provided by or under the direction of a physician, artificial insemination, and invitro fertilization, gamete intrafallopian transfer procedures, zygote intrafallopian transfer procedures and any related prescription medication treatment,

xvii. charges for the reversal of a sterilization procedure,

xviii. charges for therapy, supplies, or counseling for sexual dysfunctions or inadequacies,

xix. charges for or related to sex change surgery or any treatment of gender identity disorders,

xx. charges for any services or supplies if the provision is prohibited by any law of the jurisdiction in which the individual resides at the time the service or supply is received,

xxi. any services or supplies provided to treat injuries or sickness caused by an act of war that occurs while a Participant is covered by the Retiree Health Plan,

xxii. aromatherapy, hypnotism, massage therapy and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institute of Health,

xxiii. megavitamin and nutrition based therapy, nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs or enteral feedings and other nutritional and electrolyte supplements, infant formula, donor breast milk, nutritional and dietary supplements, diets for weight control or treatment of obesity, food of any kind, oral vitamins and oral minerals,

xxiv. appliances for snoring,

xxv. cosmetic procedures including: pharmacological regimens, nutritional procedures or treatments, scar or tattoo removal or revision procedures such as abrasion, chemosurgery and other skin abrasion procedures, skin abrasion procedures including those preformed as a treatment for acne, replacement of existing breast implant if the earlier breast implant was performed as a cosmetic procedure; provided, however, that replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a mastectomy,

xxvi. physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation,

xxvii. weight loss programs whether they are under medical supervision, weight loss programs for medical reasons are also excluded.

xxviii. not prescribed, recommended and approved by an attending physician,

xxix. inpatient stays for an excluded service,

xxx. custodial care, whether provided at home or in a nursing home or other institution,

xxxi. ambulance services when used as routine services,

xxxii. blood or blood plasma that is replaced by or for the patient,

xxxiii. any care provided by the Participant, the spouse, child, brother, sister or parent of a Participant,

xxxiv. personal comfort items, such as television, telephone, beauty/barber service, guest service, air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers,

xxxv. treatment of flat feet, subluxation of the foot, shoe orthotics, hygienic and preventive maintenance foot care/cleaning and soaking the feet,

xxxvi. applying skin creams to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involved,

xxxvii. false teeth;

xxxviii. doctor's services or X-rays involving one or more teeth, the tissue or structure around them, the alveolar process of the gums, exclusion applies even if the condition being treated involves a part of the body other than the mouth such as temporomandibular joint disorders or malocclusion involving joints or muscles. The exclusion does not apply to treatment or removal of a malignant tumor in the mouth or to treatment due to accidental injury to natural teeth performed within 12 months of the accident.

xxxix. Cancelled office visits of missed appointments,

xl. Ecological and environmental medicine, diagnosis and treatment,

xli. Special supplies such as non-prescription sunglasses and subnormal vision aids,

xlii. vision training and eye surgery to correct nearsightedness, farsightedness or astigmatism, special supplies such as non-

prescription sunglasses and subnormal vision aids, anti-reflective coatings, replacement of lenses or frames that are lost, stolen or broken, duplicate or spare eyeglasses or frames for eyeglasses, lenses and frames furnished or ordered because of an exam that was done before the person became eligible for coverage, any eye or ear exam that is required by an employer as a condition of employment, that an employer is required to provide under a labor agreement, or that is required by any law of any government,

xliii. any hearing aid that is Experimental, Investigational or Unproven, or any hearing care service or supply that does not meet professionally accepted standards, and

xliv. any supply or service received before the date the person became eligible for coverage.

4.09 Care Coordination

a. Care Coordination is designed to encourage an efficient system of care for non-Medicare-eligible Participants including admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. A Participant has to notify care coordination for certain therapeutic treatments. The care coordination activities are not a substitute for the medical judgment of a Doctor. The Participant and his or her Doctor must make the ultimate decision as to what medical care to receive. Care coordination determines whether services or supplies are Covered Health Services. No benefits are payable unless Care Coordination determines the services and supplies are covered under the Plan.

b. Care Coordination is triggered when the Plan Administrator receives notification of certain treatments or services including but not limited to:

i. inpatient stays: emergency admission requires notification within two business days and a scheduled inpatient stay requires notification at least five business days before the scheduled admission;

ii. home health care services;

iii. durable medical equipment (over $1,000);

iv. private-duty nursing;

v. prosthetic devices if device costs more than $1,000;

vi. reconstructive procedures;

vii. accidental dental services; and

viii. transplant services that require at least seven business days before the evaluation, donor search, organ procurement, tissue harvest or transplant.

c. Approval by Care Coordination does not guarantee that benefits are payable under this Plan. Benefits are based on: the covered health services actually performed or given, eligibility on the date the covered health services are performed or given, co-payments, deductibles, coinsurance, maximum limits, and all other terms of the Plan. In some instances, benefits are reduced if a Participant does not notify Care Coordination. If a Participant does not provide notice for certain inpatient stays, the Participant is responsible for $100 per day of the charges normally covered under the Plan, up to a maximum of $500. This amount is payable in addition to the Plan's deductible and does not count toward out-of-pocket limits.

ARTICLE V

Medicare

5.01 Medicare Benefits

a. The Retiree Health Plan coordinates benefits to the fullest extent possible under law with other group health plans and Medicare Part A and Part B but not Medicare Part D. The Program works together with Medicare Part A and Part B coverage and automatically offsets Medicare approved charges for reimbursement. A Medicare Participant must have Medicare Parts A and B to ensure that the highest level of benefits available.

b. When the Plan Administrator coordinates benefits with Medicare, the Plan Administrator follows these steps to calculate benefits:

i. the Plan Administrator uses Medicare's approved charge for Covered Services.

ii. the Plan Administrator reduces the Medicare approved charge by the amount that Medicare paid or would have paid if a Medicare Participant had enrolled in Medicare Part B.

iii. the Plan Administrator applies the Retiree Health Plan's appropriate inpatient and/or medical and/or pharmaceutical deductible.

iv. the Plan Administrator calculates the amount that the Plan pays of the remaining amount based on the Covered Services and how the Plan pays for those services.

v. Medicare benefits become effective on the first day of the month in which a Participant is eligible for Medicare. Persons born on the first day of the month become Medicare eligible on the first day of the prior month.

vi. If a Participant becomes Medicare-eligible prior to his or her 65th birthday, the Participant must notify Employee Benefits.

If a spouse who did not work outside the home is older than a retiree, the spouse is eligible for Medicare Part A benefits at age 65 only if the retiree is eligible for Social Security benefits, regardless of the retirement age.

5.02 Medicare Part D and the Prescription Drug Plan

Effective January 1, 2013, the Companies will cease their participation in the Retiree Drug Subsidy Program and adopt an EGWP. In accordance with the rules governing the EGWP, each Medicare eligible Participant must directly enroll, or have the Pharmacy Benefit Manager assist in the enrollment, for Medicare Part D.

ARTICLE VI

Vision Care Benefits

6.01 Vision Care Benefits

Vision care benefits are included as part of the Retiree Health Plan. Benefits include routine vision care examinations and a subsidy towards the cost of eyeglasses - including lenses, frames or contact lenses - if the eyeglasses or contact lenses are required to correct vision.

Vision care benefits are provided, to both Medicare and non-Medicare-eligible participants, at either no cost or a reduced cost when a Participant uses a Network Provider affiliated with General Vision Services, Comprehensive Professionals and Vision World, or other vision care provider chosen and participating as a Network Provider. Non Network Provider services are covered according to a designated schedule of benefits.

a. Covered Services

The Retiree Health Plan covers a vision examination performed by an ophthalmologist or optometrist licensed to perform vision examinations and prescribe lenses. Vision care benefits are not subject to a deductible or coinsurance. The expenses incurred do not go towards an annual out-of-pocket limit. All vision care expenses incurred by the Retiree Health Plan are included in a Participant's lifetime maximum benefit.

In every 24 consecutive calendar months, each Participant is eligible for one eye examination and one pair of eyeglasses or contact lenses, as well as frames adequate to hold the lenses, prescribed by an ophthalmologist or optometrist. Lenses must meet the standards of the American National Standards Institute. Also, included are the following:

i. a case history,
ii. tests of visual acuity,
iii. external examination and measurement,
iv. interior examination with ophthalmoscope,
v. examination of papillary reflexes and eye movements,
vi. retinoscopy,
vii. subjective refraction,
viii. coordination measurements,
ix. tonometry,
x. medicating agents for diagnostic purposes, if applicable, and
xi. if required, an analysis of the findings with recommendations and a prescription.

b. Services Available From Network

i. Providers No-Cost Services. A comprehensive eye examination, including testing for glaucoma, a lens or lenses including single vision bifocals, trifocals or lenticular lenses, glass or plastic lenses, and tinting of glasses, and a frame with a retail value up to $70, are provided at no cost by a Vision Network Provider.

ii. Reduced-Cost Services. Additional services available from a vision Network Providers include a frame with a retail value over $70 and contact lenses instead of lenses and a frame. A $70 credit is applied toward the regular retail price of a frame or contact lenses at Vision Network Providers. You're responsible for paying 70% of the difference between the retail price and the $70 credit.

iii. Optional Services. Optional services at vision Network Providers include photosensitive single-vision lenses - $7.50; photosensitive bifocal lenses - $15; invisible bifocal lenses - $25; and a second pair of glasses - 30% discount from the regular retail price.

c. Services from a Non Network Vision Provider

The Retiree Health Plan will pay up to the following maximum amounts for Covered Services from a Non Network vision provider: an eye examination - $20; eyeglasses - $25 for lenses and $20 for frames; contact lenses -$45 instead of eyeglass lenses and frames.

ARTICLE VII

Prescription Drug Plan

7.01 Prescription Drug Plan

If a Participant is covered by an HMO, prescription drug coverage is provided by the HMO. If a Participant elects Medicare Part D, prescription drug coverage is provided by Medicare Part D. Coverage under the Prescription Drug Plan is not available to a Participant who is covered by an HMO or a Medicare Part D plan.

The Prescription Drug Plan provisions pertain to Medicare and non-Medicare-eligible participants; provided, however, that, effective January 1, 2006, the Prescription Drug Plan only pertains to a Medicare Eligible Participant who has not elected coverage under Medicare Part D. The Prescription Drug Plan provides benefits for prescription drugs through a retail and a mail-order prescription program.

Effective January 1, 2013, only a non Medicare Eligible Participant may participate in the Prescription Drug Plan. A Medicare Eligible Participant must participate in the EGWP or elect Medicare Part D.

7.02 Deductible for Coverage Under Prescription Drug Plan

In order to access coverage under the retail pharmacy program, each CECONY Retiree or his or her Covered Eligible Dependent must meet an annual prescription drug deductible. Each O&R Retiree who is covered under the Retiree Health Plan, is automatically covered.

After meeting the annual individual deductible, if applicable, each individual pays a specific co-payment for each prescription. The amount of your co-payment depends on whether he or she is a CECONY Retiree, an O&R Management Retiree, or an O&R Local 503 Retiree and whether the prescription is filled with a generic or name-brand drug. Current plan deductibles and co-payments are shown in the applicable Schedule of Benefits.

7.03 Co-payments Under the Prescription Drug Plan

Co-payments are required whether drugs are accessed through the retail or mail order program. The amount of the co-payment depends upon whether the drug is filled by retail or mail order and whether the drug is filled with generic or brand. Caremark may contact a Participant's Doctor after receiving a prescription to request consideration of an alternative therapy, a preferred drug list product or a generic equivalent. Any resultant action will only be taken when it is explicitly authorized by the Participant's Doctor's office. This action may result in a Participant's doctor prescribing a different course of medication, brand name product or generic in place of the original prescription.

a. Covered Drugs. The Prescription Drug Plan covers most legend drugs and medicines that require a prescription from a doctor. Medications addressing the following therapies or medications require notification to and coordination with Caremark. This list is subject to change from time to time and within the sole and absolute discretion of the Plan Administrator or the Plan Administrator or the Company.

i. Growth Hormone - Nutropin AQ®, Nutropin Depot®, Nutropin®, Protropin®, Humatrope®, Geref®, Genetropin®, Norditropin®, Saizen®, Lupron®
ii. Multiple Sclerosis – Copaxone®, Avonex®, Betaseron®, Novantrone®, Rebif®
iii. Hepatitis B & C – PEG-Intron™/Rebetol®, Rebetron®, Roferon®, Infergen®
iv. Arthritis (Osteo and Rheumatoid) – Kineret™, Enbrel®, Remicade®, Synvisc®, Hyalgan®
v. Respiratory Syncytial Virus (RSV) – Synagis®
vi. Pulmonary Hypertension – Tracleer™
vii. Anemia – Epogen®, Procrit®, Neupogen®, Leukine®, Aranesp™, Neumega™
viii. Immune Deficiency – IGIV and others
ix. Bleeding Disorders – Recombinant and Monoclonal Factors VIII & IX, Stimate®

7.04 Maintenance Prescription Drugs

Insulin and maintenance prescription drugs are covered under the Prescription Drug Plan. Maintenance prescription drugs may be dispensed in amounts up to 100-unit doses, but never more than a 34-day supply through the retail program. The mail order program provides up to a 90-day supply.

The mail-order prescription program covers insulin as well as maintenance prescription drugs - those taken on a regular or long-term basis to treat such conditions as heart disease, high blood pressure, ulcers, arthritis, emphysema, diabetes or other continuing medical problems. Needles and syringes are covered only if they are used for the treatment of diabetes. The mail-order program only covers oral contraceptives with a medical diagnosis. The mail-order service covers needles and syringes used in the treatment of diabetes.

7.05 Refills

The Prescription Drug Plan covers prescription refills that may be filled only up to one year from the date of the original prescription.

7.06 Network Pharmacies

After meeting an annual Prescription deductible, a Participant will be responsible for an applicable co-payment for each prescription filled at a Network retail pharmacy.

7.07 Non-Network Pharmacies

After meeting an annual Prescription deductible, the Prescription Drug Plan reimburses a Participant 100% of Caremark's Network retail price minus the applicable co-payment. There may be a significant difference between the Non-Network Pharmacy cost and the discounted Network cost.

7.08 Prescription Drug Exclusions

a. The following drugs, supplies, and services are not covered under the Prescription Drug Plan. The list of exclusions is subject to change from time to time, at the sole discretion of the Plan Administrator and Plan Administrator.

i. non-legend drugs,
ii. Experimental, Investigational or Unproven drugs or drugs labeled "Caution - limited by federal law to *"investigational use"*
iii. cosmetic drugs,
iv. over-the-counter medications (except insulin),
v. therapeutic devices or appliances, including hypodermic needles and syringes, support garments and other non-medicinal substances, (however, the mail-order service does cover needles and syringes used in the treatment of diabetes),
vi. fertility drugs or test devices,
vii. immunization agents, biological sera, blood or blood plasma,
viii. charges for the administration or injection of any drug,
ix. medication taken by or administered to a patient in a licensed hospital, nursing home or skilled nursing facility that operates a facility for the dispensing of prescription drugs on its premises,
x. any other pharmaceutical items not classified as legend drugs,
xi. levonorgestrel (Norplant),
xii. topical monoxidil[1] (Rogaine) for the treatment of alopecia, *or*
xiii. prescriptions which an eligible person is entitled to receive without charge under any workers compensation law, or any municipal, state or federal program.

[1] Please note that oral monoxidil is covered.

ARTICLE VIII

Coordination of Benefits, Subrogation and Recovery

8.01 Coordination of Benefits

The Program coordinates benefits with other group health plans, government plans, (other than Medicaid and Medicare Part D) States' "no-fault" motor vehicle coverage, and other insured or uninsured plans, programs, or institutions that provide or pay for health care coverage. In accordance with the coordination of benefit provisions, the Program, taking into account any other health plan, dental plan, vision plan and/or prescription drug plan and the terms of this Program, in the aggregate, may reimburse a Participant up to a total of but not more than 100% of the Charge. Depending upon which plan pays first, the Program may reduce the amount of benefits it provides to the Participant. In the event an HMO has a coordination of benefits provision that is inconsistent with this Coordination of Benefits section, the HMO coordination provision will be deemed operative. The Program is always secondary to any automobile insurance coverage, including, but not limited to, no-fault coverage and uninsured motorist coverage, and to any medical payment provision under homeowner's or renter's insurance.

To administer the Coordination of Benefits, the Program reserves the right to: exchange information with other plans involved in paying claims; require that each Participant and/or his or her provider furnish any necessary information; or recover any overpayment from a Hospital, Doctor, Dentist, other Health care Provider, other insurance company, or a Participant or the Dependent of the Participant.

If this Program should have paid benefits that were paid by any other plan, this Program may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Program, and this Program will be fully discharged from any liability it may have to the extent of such payment.

This Program follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program (unless the benefit is covered in the Schedule of Medical Benefits). The dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will normally pay secondary medical benefits only when the coordinating primary plan provides medical benefits.

If this Program is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Program will consider the reasonable cash

value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Allowed Charge.

If this Program is secondary, and if the coordinating primary plan does not cover healthcare services because they were obtained out of network, benefits for services covered by this Program will be covered by this Program subject to the rules applicable to COB, but only to the extent they would have been covered if this Program were the primary plan.

If this Program is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Program, this Program will not relinquish its secondary position. However, if this Program advances an amount equal to the benefits it would have paid had it been the primary plan, this Program will be subrogated to all rights the Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Program to pursue any claims against the other plan for reimbursement of the amount advanced by this Program.

8.02 Coordination of Benefits and the Order of Payment

When a Participant is covered by the Program and another plan, the following rules apply. If the other plan does not have a coordination of benefits provision similar to this provision, the other plan pays first, regardless of these rules.

a. **Non-Dependent or Dependent Rule.** The plan covering the Participant other than as a dependent pays before the plan covering the Participant as a dependent pays. There is a special exception to the "non-dependent or dependent rule." If the plan covering the Participant as a dependent is primary to Medicare and the plan covering the Participant other than as a dependent is secondary to Medicare, then the order of benefits is reversed so that the plan covering the Participant as a nondependent is covering the Participant as a dependent. Therefore, if the Program and another group plan covers the Retiree, who is also covered by Medicare, then the plan covering the Participant as a dependent is primary.

b. **Child Covered under More than One Plan –Birthday Rule**. If the Covered Dependent is a Dependent Child covered under more than one plan then the birthday rule applies. The plan of the parent whose birthday falls earlier in the year (regardless of the year of birth) pays first if the parents are married; the parent are not separated (whether or not they ever have been married); or a court decree awards joint custody without specifying that one parent has the responsibility to provide

health care coverage. If both parents have the same birthday, even if they were born in different years, the plan that has covered one of the parents for the longer period of time pays first. If one parent's plan follows the birthday rule and the other doesn't, the father's plan pays first. If both parents are the same sex, and have the same birthday, then the plan that has covered one of the parents for the longer period of time pays first.

c. **Child Covered Under More Than One Plan–Court Decree Determines**. If the parents are separated or divorced, benefits are paid for the Dependent Child are determined in this order. First, the plan of the parent who is responsible for the health care expenses of the Dependent Child according to, and with actual knowledge by the plan of that parent of the specific terms of, a court decree. Second, if the court decree provides for joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plan of the parent with custody of the Dependent Child pays. The plan of the other parent is the Secondary plan. Third, the plan of the spouse of the parent with financial responsibility for the Dependent Child and without coverage for that Dependent Child's health care services or expenses. Fourth-by the plan of the parent not having custody of the Dependent Child.

d. **Coverage for Child in Other Situations**. If the parents are not married, are separated (whether or not they ever were married) or divorced, and there is no court decree allocating responsibility for the Dependent Child's health care expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is: the plan of the custodial parent; the plan of the spouse of the custodial parent; the plan of the noncustodial parent; and then, the plan of the spouse of the noncustodial parent.

e. **Active or Inactive Rule.** If a plan covers a Participant as a retiree, dependent child, or spouse, that plan pays after another plan covering the Participant as an active employee or dependent of an active employee. (This provision does not apply if the other plan does not have a provision regarding laid-off or retired employees. In that case, each plan determines its benefits after the other.)

f. **Continuation Coverage Rule.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law (e.g., COBRA continuation coverage) also is covered under another plan, the

plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

g. If none of the rules above determines which plan pays first, the primary plan is the plan that has covered the Participant for a longer period of time.

h. **Coordination with Medicare and Another Plan**. Special rules apply if a retiree is eligible for Medicare and is covered under another plan. The rules are set forth in the Medicare section of the Plan.

8.03 Refund of Overpayments

a. If the Plan pays expenses and all or some of those expenses were either not paid or legally did not have to be paid by the Participant, or exceeded the allowable benefits under the Plan ("Overpayment"), the Participant, or any other person or organization that was paid, must refund the Overpayment to the Plan.

b. The amount of the Overpayment equals the amount paid in excess of the amount that should have paid under the Plan. If the Overpayment is due from a third party, the Participant will agree to assist in obtaining the Overpayment when requested.

c. If the Participant does not promptly repay the full amount of the Overpayment, the Plan may reduce the amount of any future benefits that are payable. The reductions will equal the amount of the required Overpayment.

8.04 Subrogation

a. If a Participant suffers an injury, illness or sickness as a result of a negligent or wrongful act or omission of a third party, the Program has the right to pursue subrogation where and to the extent permitted by law. This subrogation rights extends the recovery of all directly and indirectly related medical services and benefits paid, either directly or through a trust, directly or indirectly to or on behalf of, the Participant.

b. The Program or Employer will be subrogated and succeed to the Participant (or, in the event of the death or incapacity of the Retiree, the lawful beneficiary or estate of the Retiree) under any theory of right of

recovery against a third party. Each Employer may use the right of subrogation to the extent that the amount received through a third-party settlement or satisfied judgment is identified in the settlement or judgment as amounts paid or incurred by the Employer or Program the same medical services and benefits. As a condition of participation in the Program, each Participant consents and agrees that his or her Employer, in its sole discretion, may exercise this right when requested.

c. In the event of any payment under the Program, the Program, through its Plan Administrator, or Named Fiduciary, shall be subrogated to all the rights of recovery of the Participant and the Participant will execute all papers required and shall do everything that may be necessary to secure such rights including the execution of such documents necessary to enable the Program to bring suit in the name of the Participant. If a Participant has a claim against another person or third party for payment of the medical or other charges, the Program will be subrogated to all rights the Participant may have against that other person or third party and will be entitled to reimbursement.

d. The Participant must:

i. assign or subrogate to the Program his or her rights to recovery when this provision applies and acknowledge that the Program's rights will be considered as the first priority claim against third parties, to be paid before any other of claims are paid;

ii. authorize the Program to sue, compromise and settle in the Retiree's name to the extent of the amount of medical or other benefits paid and expenses incurred by the Program;

iii. reimburse the Program out of any recovery made from the other person, the other person's insurer or the third party, the amount of medical or other benefits paid and expenses incurred by the Program;

iv. notify the Program in writing of any proposed settlement and obtain the Program's written consent before signing any release or agreeing to any settlement;

v. do nothing to prejudice the rights of the Program under this provision, either before or after the need for services or benefits under the Program;

vi. whether or not the Participant has been fully compensated, allow the Program to collect from the proceeds of any full or partial recovery that the Participant or legal representative of

the Participant may obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided;

vii. hold in trust for the benefit of the Program under these subrogation provisions any proceeds of settlement or judgment;

viii. authorize the Program to recover reasonable attorney fees incurred in collecting proceeds held by the Participant; and

ix. execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested.

e. All amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid and expenses incurred by the Program in collecting this amount. The right of reimbursement also applies when a Participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

f. The provisions of this subrogation section will be applied consistent with the decision in the most recent Supreme Court case.

ARTICLE IX

Effect of Medicare and Other Government Plans

9.01 Medicare

When a Retiree becomes eligible for or entitled to Medicare, the Program pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. The Program will not coordinate with Medicare Part D but coordinates with prescription drug coverage covered by Medicare Part B.

9.02 When the Program is Primary to Medicare

The Program pays primary to Medicare for Participants who are Medicare eligible if eligibility for Medicare is due to end state renal disease (ESRD). The Program is primary only during the first 30 months of entitlement to Medicare due to ESRD. However, if the Participant was already entitled to Medicare based on age or disability when the Participant became eligible due to ESRD, Medicare continues to be primary after an aged or disabled Participant has ESRD.

9.03 Medicare Primary to the Program

Medicare pays primary to the Program for Participants who are Medicare eligible if:

a. eligibility is due to disability and the Participant does not have "current employment status" with the Company as defined by the federal law and determined by the Company, or

b. eligibility for Medicare is due to ESRD, but only after the first 30 months of entitlement to Medicare due to ESRD,

c. a Participant is entitled to Medicare on account of age, or

d. A Participant is entitled to Medicare on account of disability and has COBRA coverage under this Plan.

9.04 Medicare Enrollment Requirements

The Participant must enroll for Medicare Parts A and B. When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under the Medicare Supplemental Plan, whether or not the Participant has enrolled for Medicare. If Medicare pays first, the Participant should enroll for both Medicare Parts A and B when he or she is first

eligible, otherwise, the expenses may not be covered by the Retiree Health Program or Medicare.

9.05 How The Retiree Health Program Pays When Medicare Is Primary

If Medicare pays benefits first, the Retiree Health Program pays benefits as described below. This method of payment applies to a Participant who is Medicare eligible whether or not he or she actually enrolls in Medicare. It applies to a Participant if and when he or she becomes eligible under Medicare and Medicare is the primary payer.

i. The Medicare Supplemental Plan (or the Retiree Health Plan, if applicable) first determines whether the expense is a Covered Service. In general, if Medicare does not cover the expense, the Medicare Supplemental Plan does not cover the expense. There are some very limited exceptions.

ii. If the expense is a Covered Service, the Medicare Supplemental Plan determines the Medicare Allowable Amount (also known as the Medicare Allowable Charge) .

iii. The Medicare Supplemental Plan then subtracts the Medicare Allowable Charge from the Medicare Supplemental Plan and pays only the difference (if any) between benefits and the Medicare Allowable Charge. The Medicare Supplemental Plan assumes the Retiree has paid any and all Medicare-based deductions.

iv. The Medicare Allowable Charge which is subtracted from the Plan's benefits is determined as the amount that was paid or would have been payable to a Medicare Eligible Participant under Medicare even if the Participant is not enrolled for Medicare Parts A and B. Benefits are determined as if the Participant were covered under Medicare Parts A and B.

9.06 Government Programs (Other than Medicare and Medicaid)

If the Retiree is also covered under a Government Plan, the Retiree Health Program does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Retiree under the Government Plan. This provision does not apply to any Government Plan which by law requires the Retiree Health Program to pay primary.

ARTICLE X

Contributions

10.01 Retiree Contributions

a. Each Participant is required to pay a monthly Contribution for medical, hospital and vision care. Contributions will be deducted monthly, on an after-tax basis, from his or her Pension or, if such Participant is not collecting a monthly Pension, in any other manner approved by the Plan Administrator.

b. Each Participant is required to pay a monthly contribution for prescription drug coverage. Contributions will be deducted monthly, on an after-tax basis, from his or her Pension or, if such Participant is not collecting a monthly Pension, in any other manner approved by the Plan Administrator.

c. From time to time, upon a determination by the Company, the Plan Administrator may change the contributions, deductibles and co-payment amounts, and the Plan Administrator will notify affected Participants in advance of the effective date of any such change. Any increased in costs is the sole responsibility of the Retiree, except to the extent that the Company, in its sole discretion, elects to increase its contribution.

10.02 Company Contribution

a. For Plan Years beginning before January 1, 2008, the Company shall determine from time to time what amount, if any, in excess of any Retiree contributions, each Employer will contribute to the cost of the Program.

b. Company Limit. As adopted by the Board on January 17, 2002, beginning on January 1, 2008, the Company will define a fixed dollar amount that CECONY and each employer may elect to spend for each Plan Year beginning in Plan Year 2008. If the company elects to contribute to the Program, the amount of the Company's contribution will be increased, if any, each year through an automatic adjustment to reflect general inflation for the preceding year, up to the change in the Consumer Price Index Urban Wage Earners. All Participants in the

Retiree Health Program will be subject to this change other that those Participants whose monthly Pension is $1,000 or less as of April 2008.

c. Company Limit. As adopted by the Board on January 17, 2002, beginning on January 1, 2008, the Company will define a fixed dollar amount that CECONY and each employer may elect to spend for each Plan Year beginning in Plan Year 2008. If the company elects to contribute to the Program, the amount of the Company's contribution will be increased, if any, each year through an automatic adjustment to reflect general inflation for the preceding year, up to the change in the Consumer Price Index Urban Wage Earners. All Participants in the Retiree Health Program will be subject to this change other that those Participants whose monthly Pension is $1,000 or less as of April 2008.

ARTICLE XI

Termination of Coverage

11.01 When Coverage Ends

a. Coverage for any Participant ends on the earliest of the following:

i. the day the Retiree Health Program ends;
ii. the last day of the month for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due;
iii. when a Participant voluntarily cancels coverage in writing;
iv. if the Participant is a Dependent Child, when the Dependent Child becomes covered as an employee under another group health plan;
v. if the Participant is a Spouse or Dependent Child, the last day of the month when the Spouse or Dependent Child ceases to belong to an eligible group; for example, when a child no longer meets the definition of a Dependent Child or a Spouse becomes divorced from the Retiree;
vi. if coverage is for a Spouse, Surviving Spouse or Dependent Child, the last day of the month that coverage is terminated under the Plan;
vii. for the Dependent Child, the last day of the month in which the Retiree and/or if later, the Surviving Spouse, dies;
viii. for the Spouse and Dependent Child, the last day of the month in which the Retiree dies and the Spouse is not eligible for a survivor retirement Pension from the Retirement Plan;
ix. the date the Retiree engages in fraud, misrepresentation or providing false information and coverage ends for the Retiree and his or her Covered Eligible Dependents;
x. the date the Retiree engages in conduct which, if performed as an active employee, would have caused the Retiree to be ineligible for COBRA and coverage ends for the Retiree and his or her Covered Eligible Dependents;
xi. Beginning of the month in which a Medicare Eligible Participant enrolls in Medicare Part D- coverage ends under the Prescription Drug Plan.

b. Rescission or cancellation

If a Participant or Dependent intentionally misrepresents information to the Program or to the Company, or knowingly misinforms, deceives, or misleads the Program, or knowingly withholds relevant information, coverage may be cancelled retroactively to the date deemed appropriate by the Plan Administrator. Further, a Participant or Dependent may be required to reimburse the Plan for Claims paid by the Plan. The Plan may choose to pursue civil and/or criminal action. The Plan Administrator may determine that a Participant or Dependent is no longer eligible for coverage under the Plan because of such actions. In addition if a Participant or Dependent is terminated from eligibility under any benefit plan sponsored by the Company or any of its subsidiaries or affiliates because of the violation of a similar section of that benefit plan, or has been terminated on account of gross misconduct resulting in a forfeiture for COBRA coverage, the Plan Administrator may determine that a Participant and Dependents are disqualified from eligibility for coverage under the Program.

c. Other Events Affecting Coverage

i. Each CECONY Retiree and O&R Retiree understand that the Plan Administrator reserves the right to require proof of eligibility of any person who is enrolled as a Covered Eligible Dependent within the time specified by the Plan Administrator or the Company.

ii. If an individual ceases to meet the eligibility requirements, the Retiree must notify the Plan Administrator or the Employer. If the Retiree does not notify the Plan Administrator or the Employer of the change in eligibility requirements, any claims made or incurred for the individual who has ceased to meet the eligibility requirements will be considered to be a false claim and a fraudulent act.

iii. Meeting the eligibility requirements and providing required proof of eligibility are material conditions of enrollment and continued coverage under the Retiree Health Program.

iv. Enrolling a person who does not meet the eligibility requirements, failing to notify the Plan Administrator or the Company immediately if a person ceases to meet the eligibility requirements, or refusing or failing to provide required proof of eligibility constitutes fraud or an intentional misrepresentation of material fact and is prohibited by the Retiree Health Program.

v. If a person does not meet the eligibility requirements at the time of enrollment, Plan Administrator or the Company will cancel that person's coverage as of the date of enrollment.

vi. If a person ceases to meet the eligibility requirements at a time after enrollment, Plan Administrator or the Company will cancel that person's coverage as of the date that person ceased to meet the eligibility requirements

vii. If a person refuses or fails to provide required proof of eligibility for a person, the Plan Administrator or the Company will cancel that person's coverage as of the date of enrollment or such other date as Plan Administrator or the Company determines, in each's sole discretion.

11.02 COBRA Coverage

In order to be eligible for COBRA Coverage, a Participant must be a Qualified Beneficiary. If the coverage of a Qualified Beneficiary would terminate due to a Qualifying Event, then the Qualified Beneficiary is entitled to elect COBRA Coverage.

Additionally, effective as of January 1, 2014, a Participant may seek coverage through the Health Insurance Marketplace that may cost less than COBRA Coverage. A Participant who is losing coverage under the Retiree Health Program will have, in general, 60 days to seek coverage in the Health Insurance Marketplace from the time she or he loses coverage to enroll in the Marketplace or during the open enrollment period for the Marketplace coverage.

11.03 Notification Requirements and Election Period for COBRA Coverage

a. If the Qualifying Event is the divorce, legal separation or loss of eligibility status of an Eligible Dependent, in order to elect COBRA Coverage, the affected Qualified Beneficiary must notify Employee Benefits or the Plan Administrator within 60 days of the Qualifying Event. If a Qualified Beneficiary fails to notify Employee Benefits or the Plan Administrator of one of these Qualifying Events within the 60-day period, Employee Benefits or the Plan Administrator will not provide COBRA Coverage to the affected Qualified Beneficiary.

b. If the Qualifying Event is the death of the Retiree, the Plan Administrator, will notify the Qualified Beneficiary(ies) of his or her COBRA rights.

c. In each case, COBRA Coverage must be elected by the Qualified Beneficiary no later than 60 days after the Qualifying Event occurs or 60 days after the Qualified Beneficiary receives his or her COBRA notice. The initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

11.04 COBRA Terminating Events

COBRA Coverage ends on the earliest of the following events.

a. If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time within the first 60 days of COBRA Coverage, then the Qualified Beneficiary may elect an additional 11 months of COBRA Coverage (for a total of 29 months of COBRA Coverage). The notice of the Social Security Disability determination must be provided within 60 days of the actual disability determination and before the end of the original 18-month COBRA period. The Qualified Beneficiary must agree to pay up to 150% of the required premium for the additional 11 months. If the disabled Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are entitled to the additional 11 months of COBRA Coverage at 150% of the required premium. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, COBRA Coverage may be terminated on the first day of the month that begins no more than 30 days after the date of determination that person is no longer disabled.

b. If the Qualifying Event is the death, divorce or legal separation of the Retiree, or loss of eligibility by an Eligible Dependent who is a child, COBRA coverage ends 36 months from the date of that Qualifying Event.

c. COBRA Coverage ends on the date coverage terminates for failure to make timely payment of the premium.

d. COBRA Coverage ends on the date, after electing COBRA Coverage, that coverage is first then obtained under any other group health plan. If such coverage, other than Medicare, contains a limitation or exclusion

with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all services except those services that are subject to the pre-existing condition limitation or exclusion.

e. COBRA Coverage ends on the date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy.

f. COBRA Coverage ends on the date the entire Retiree Health Program ends.

11.05 Certificate of Creditable Coverage

Certificates of Creditable Coverage will no longer be required for Plan Years beginning after December 31, 2014. For Plan Years before January 1, 2015, the following rules apply.

a. The certificate of creditable coverage is a written document that reflects certain details about an individual's creditable health coverage.

b. The Retiree Health Program will provide certificates to a Participant as he or she loses coverage, or begins or ends COBRA. The certificate will be furnished automatically to: a Participant within a reasonable time after the Participant loses coverage; a Qualified Beneficiary entitled to elect COBRA Coverage at a time no later than a notice is required to be provided for a qualifying event under COBRA; or a Participant who is a Qualified Beneficiary and elected COBRA Coverage, after either cessation of COBRA Coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums. In addition, a certificate also is required to be provided upon the request of, or on behalf of, a Participant not later than 24 months after the Participant loses coverage. In this case, the certificate is required to be provided at the earliest time that the Program, acting in a reasonable and prompt fashion, can provide the certificate.

11.06 Form of Certificate

The certificate must be provided in writing. When such an arrangement is acceptable to a new plan or issuer, the individual, and the source of prior coverage, the certification information may be provided by telephone. The Retiree Health Plan may simply state in the certificate that the Participant has at least 18 months of creditable coverage that it not interrupted by a

significant break and indicate the date coverage ended. The certificate must disclose the following: the date any waiting or affiliation period began (the ending date for a waiting or affiliation period will always be the date coverage begins and thus is not required to be separately identified in a certificate); the date coverage began; and the date coverage ended or indicate if coverage is continuing (these dates would include any period of COBRA Coverage).

11.07 Creditable Coverage Certificates No Longer Required

Beginning December 31, 2014, the rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions, as set forth in Treasury Regulation § 54.9815-2704T for rules prohibiting the imposition of a preexisting condition exclusion. The amendments made under this section apply.

ARTICLE XII

Trust Fund

12.01 Funding

The Retiree Health Program is currently a contributory welfare benefit plan. CECONY contributions for the payment of benefits for CECONY Retirees are made to a Code Section 401(h) Account ("401(h) Account") within the Retirement Plan and two trust funds established by CECONY under and approved by the Internal Revenue Service as tax-exempt Code Section 501(c)(9) voluntary employee beneficiary associations ("CECONY VEBAs").

The 401(h) Account and the CECONY VEBAs work together with CECONY Retirees' and Employers' contributions to pay for the hospital, medical, vision care and prescription drug benefits under the Program. The 401(h) Account and the VEBAs contain provisions to avoid duplication of benefits. Contributions by CECONY Retirees are transferred to the Trustee and deposited in the VEBAs.

O&R contributions for the payment of benefits for O&R Retirees are made to two trust funds established by O&R under and approved by the Internal Revenue Service as tax-exempt Code Section 501(c)(9) VEBAs ("O&R VEBAs").

The amount, if any, of an Employer Contribution is determined by the Company with the assistance of its actuary and other professionals. Whether and how much the Company contributes to the 401(h) Account and/or the VEBAs is solely the decision and within the sole discretion of the Company. The Company has the sole authority to determine whether it will contribute towards the cost of the Program.

12.02 Special Rule for 401(h) Account

Contributions to the 401(h) Account may be commingled with assets for investment and custody purposes. All Retiree Health Program contributions and earnings thereon, if any, together with all disbursements will be recorded and accounted for in one or more separate accounts relating solely to the Program.

In the event the Company or an Employer makes a contribution to the Retiree Health Program which includes contributions allocable both to Retiree Health Program benefits and to the Retirement Plan, the Company shall clearly specify the portion of such contribution allocable to the Program.

In the event that all liabilities of the Retiree Health Program shall have been fully satisfied and there are no persons participating in the Retiree Health Program or eligible therefore, the entire balance in the 401(h) Account will be paid by the Trustee to the Company.

ARTICLE XIII

Administration and Claims

13.01 Authority

The Vice President-Human Resources, as a Named Fiduciary and Plan Administrator, has the authority to control and manage the operation and administration of the Program. The Plan Administrator may delegate such authority, as permitted by ERISA, by designating in writing the person or persons to carry out specified responsibilities. The Plan Administrator will retain copies of any such delegations of authority. Effective February 2003, UHC has assumed fiduciary responsibility for all claims brought under the Retiree Health Plan. As of January 2010, Cigna has replace UHC as the claims fiduciary.

13.02 Investment Manager

The Named Fiduciaries have the authority to appoint an Investment Manager(s) to manage, acquire and dispose of assets of the VEBAs and the 401(h) accounts.

13.03 Rights and Duties

In each instance in which the Plan Administrator or a Plan Fiduciary has the authority to take any action or make a determination, he or she does so in her full and absolute discretion. Each and every determination made by the Plan Administrator is done so with the full intention that such action or determination is final and binding. Any determination of the Plan Administrator or Plan Fiduciary that is reviewed by a court is to be reviewed by the heightened arbitrary and capricious standard.

The Plan Administrator has the authority to maintain the benefit limits at levels the Plan Administrator determines, in his or her sole discretion, to be reasonable or required by applicable law. The Plan Administrator has the authority, in his or her sole discretion, to change co-payments, deductibles, out-of-pocket and other limitations, as he/she may deem appropriate. The Plan Administrator has the authority to determine whether to provide all or any part of the benefits under the Retiree Health Program through insurance and, if so, to select one or more insurance companies to provide any such benefits. The Plan Administrator has the authority to administer claims and benefit payments under the Retiree Health Program or to delegate a Claims Fiduciary responsible for claims administration. The Plan Administrator and each entity or person delegated the authority to act as a fiduciary to provide benefits or administer claims and benefit payments shall have final authority to decide all claims and the amount of benefit payments under the provisions of Appendix I. The Plan Administrator may adopt such rules as deemed necessary, desirable, or appropriate. All rules and decisions will be uniform and consistent for all Retirees, Spouses, Domestic Partners,

Surviving Spouses and Dependent Children in similar circumstances. When making a determination or calculation, the Plan Administrator is entitled to rely upon information or advice furnished by a Retiree, Spouse, Domestic Partner, Surviving Spouse or Dependent Child, the Company, any legal counsel of the Company, each Employer, the Trustee, the enrolled actuary, and the independent qualified public accountant for the Program.

13.04 Records and Reports

The Plan Administrator shall exercise such authority and responsibility, and perform such duties, as may be required in order to comply with ERISA and the Code and governmental regulations issued there under relating to records and reports of the Program, notifications to Retirees and Surviving Spouses, registration with the Internal Revenue Service, reports to the Department of Labor and, when applicable, the Department of Health and Human Services and CMS.

13.05 Plan Administrator's Duties and Powers

The Plan Administrator shall have such other duties and powers as may be necessary to exercise his or her discretion and discharge his or her duties hereunder, including but not by way of limitation the following:

a. unless a Claims Fiduciary has otherwise been appointed and delegated the responsibility, to decide all claims and questions of eligibility and determine the amount, manner and time of payment of any benefits hereunder and to construe and interpret the Retiree Health Program as may be necessary in connection therewith,

b. to prescribe procedures to be followed by Participants filing claims for benefits,

c. to prepare and distribute, in such manner as he or she determines to be appropriate, information explaining the Program,

d. to receive from the Company, Employers, and Participants such information as shall be necessary for the proper administration of the Program,

e. to furnish the Company, upon request, such annual reports with respect to the administration of the Retiree Health Program as are reasonable and appropriate,

f. to receive and review any periodic valuation of the Retiree Health Program made by the enrolled actuary,

g. to receive, review and keep on file (as deemed convenient or proper) reports of the financial condition, and of the receipts and disbursements, of the trust funds from the trustee,

h. to appoint or employ individuals to assist in the administration of the Retiree Health Program and to perform the specific operational and administrative duties and functions necessary to Retiree Health Program administration, and

i. to receive service of legal process, as agent for the Program.

Each determination is final and binding.

13.06 Plan Expenses

Expenses that may arise in connection with administration of the Retiree Health Program and the Trust Fund, including any expenses relating to investment of assets held in the trust funds and any taxes that may be assessed or levied against the trust fund or the Program, shall be allocated between those expenses that may be paid by the Retiree Health Program and those expenses properly allocated and paid by the Employers. Expenses which may be paid by the Retiree Health Program shall be paid by the trustee from the trust funds.

ARTICLE XIV

Claims Procedure

14.01 Claims Procedure for Certain Claims Brought After January 1, 2003

The Claims Procedure in this Section applies to all claims brought before January 1, 2003, and to all claims brought after January 1, 2003, that are not Urgent Care Claims, Pre-Service Claims, Post-Service Claims or Concurrent Claims.

a. A Retiree may bring a claim for benefits under the Program. If the claim if for hospital, medical or vision benefits, the Retiree may file a claim with the Claims Fiduciary. If the claim is related to prescription drug benefits, the Retiree may file a claim with the PMB Fiduciary. If the claim relates to eligibility, a claim may be filed with the Plan Administrator.

b. In the event a claim has been denied, a Retiree may bring a claim within 60 days of the initial denial of benefits. Within 90 days following the receipt of the initial claim, the appropriate fiduciary will approve or disprove the claim. If a claim for benefits is wholly or partially denied, the fiduciary reviewing the claim will provide a written or electronic notice of the denial setting forth:

i. the specific reason(s) for the denial;
ii. reference to the specific plan provision(s) upon which the determination is based;
iii. a description of any additional material or information necessary for the Retiree to perfect a claim and an explanation of why such material or information is necessary;
iv. the appropriate direction as to the steps to be taken for a claim to be submitted for review;
v. beginning for claims brought on and after January 1, 2003, a description of the Program's review procedures and the time limits applicable to such procedures, including a statement of the Retiree's right to bring a civil action under Section 502(a) of ERISA; and
vi. beginning for claims brought on and after January 1, 2003,

c. If the fiduciary determines that additional time is necessary, written notice of the need for an extension will be furnished prior to the end of

the first 90-day-period. The fiduciary may have another 90 days to issue a response.

d. The Retiree may request a review of the initial decision by submitting to the appropriate fiduciary a written statement:

i. requesting a review of the claim for benefits;
ii. setting forth all of the grounds upon which the request for review is based and any facts in support thereof; and
iii. setting forth any issues or comments which the Retiree deems relevant to the claim.

e. The reviewing fiduciary will act upon each such review request within 60 days after either receipt of the Retiree's request for review or receipt of any additional materials reasonably requested by the reviewing Fiduciary.

f. The fiduciary shall make a full and fair review of each such appealed claim and any written materials submitted. The fiduciary may require the Company or the Retiree to submit within 30 days after receiving a written notice additional facts, documents or other evidence as is deemed necessary or advisable in the sole discretion of the reviewing fiduciary in making such a review. On the basis of the review, the reviewing fiduciary will make a determination of the Retiree's claim for benefits under the Program. The decision of the reviewing fiduciary on any appeal of a claim for benefits shall be final and conclusive upon all persons. If the reviewing fiduciary denies an appeal in whole or in part, the reviewing fiduciary shall give written notice of the decision to the Retiree setting forth the specific reasons for such denial and specific references to the pertinent Retiree Health Program provisions on which the decision is based. Such written notice shall be given no later than 120 days after the date the appeal was filed.

14.02 Claims Procedure for Certain Claims Brought After January 1, 2003

Effective on or after January 1, 2003, certain claims for benefits will be subject to new processing standards. The new standards apply only to certain claims for benefits. The new standards do not apply to questions concerning eligibility for coverage. Additionally, if prior approval is not required under the Program, the request is not a claim for benefits subject to the new standards. Requests for advance information on the Program's possible coverage of or approval for items or services do not constitute Pre-Service Claims. Each claim is classified by the Claims Fiduciary as either an Urgent Care Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim. The Claims Determination Fiduciary will determine the nature of

the claim, whether the claim has been properly filed and the number of days the Retiree Health Program has to respond to the claim.

a. **Urgent Care Claim**. If the claim is an Urgent Care Claim, the initial decision, whether adverse or not, regarding the claim will be made as soon as possible but not later than 72 hours of receipt of the properly filed claim. If the Claimant failed to provide sufficient information to determine whether, and to what extent, benefits are covered or payable under the Program, the Claims Fiduciary will notify the Claimant as soon as possible, but not later than 24 hours after the receipt of the claim by the Retiree Health Program of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with this Section. The Claims Fiduciary shall notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of -- the Program's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.

b. **Concurrent Care Claim**. The Claims Fiduciary will notify the Claimant of an adverse benefit determination at a time sufficiently in advance of a reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before the reduction or termination. If the request to extend the course of or number of treatment(s) is an Urgent Care Claim, the claim will be decided as soon as possible, taking into account the medical exigencies. A determination will be made within 24 hours after receipt of the claim, provided such claim is made at least 24 hours before the expiration of the receipt of the prescribed period of time or number of treatments.

c. **Pre-Service Claim.** If the claim is a Pre-service Claim, the initial decision must be made within 15 days of receipt of the properly filed claim.

d. **Post Service Claim.** If the claim is a Post Service Claim, the Claims Fiduciary will notify the Claimant of the adverse benefit determination within 30 days of receipt of the Claim. The first 30-day-period may be extended one time for up to an additional 30 days, provided that the Claims Fiduciary determines that the extension is necessary due to matters beyond the control of the Retiree Health Program and notifies the Claimant, prior to the expiration of the initial 30-day period, of the

circumstances requiring the extension of time and the date a determination is expected. If an extension is needed because the Claimant failed to submit necessary information, the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

e. Plan May Seek Extension in Limited Circumstances. Extensions are available for Pre-service Claims and Post-service Claims in circumstances that are beyond the control of the Program; e.g., the Retiree Health Program can extend the time needed if more information is needed from the claimant. Time is "tolled" from the point that the Retiree Health Program notifies the claimant about the need for the additional information until the claimant responds with the information.

14.03 Appeals of Adverse Benefit Determinations

a. Each Retiree and/or Claimant has at least 180 days in which to appeal an adverse benefit determination. The Claims Fiduciary will provide the Claimant with a specific reason for its denial, including identification of and access to any guidelines, rules, or protocols the Claims Fiduciary relied upon in making the adverse determination. If the denial is based on medical necessity or Experimental, Investigational or Unproven treatment, the Retiree Medical Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

b. The Retiree Health Program must also provide the claimant with access to all documents, records and other information relevant to the benefit determination, without regard to whether the Retiree Health Program relied on the material. Alternatively, the Retiree Health Program denial may state that the information is available free of charge upon request. Relevant documents include those documents generated by the Retiree Health Program to demonstrate that similarly situated claims are treated consistently.

c. The Retiree Health Program will disclose the name of medical professionals consulted as part of the claims procedure. Claimants have a right to appeal an adverse determination to a new decision maker or plan fiduciary who is not a subordinate of the initial decision maker. The second fiduciary or decision maker must be willing to accept new evidence or information. The review must be de novo.

d. If the Appeal regards an Urgent Care Claim, an expedited review process must be provided. The request for an appeal may be made in writing or submitted orally and all necessary information will be transmitted by telephone, facsimile or other expeditious methods. The Retiree Medical Plan may require arbitration as one level of appeal so long as the claimant can challenge the arbitrator's decision in court. The Retiree Medical Plan will disclose the arbitration process, the arbitrator, the relationship and the right to representation. Voluntary binding arbitration is permissible so long as no fees are imposed and challenge to court action is permitted.

e. In an Urgent Care Claim, the Claim Fiduciary will notify the Claimant not later than 72 hours after receipt of the request for a review. In a Pre-Service Care Claim, the Claims Fiduciary will notify the Claimant not later than 30 days after receipt of the request for a review. If two levels of appeals are available, each level must respond within 15 days of the request for a review. In a Post-Service Claims, the Claims Fiduciary will notify the Claimant not later than 60 days after receipt of the request for a review. If two levels of appeals are available, each level must be responded to within 30 days of receipt of the request for a review.

14.04 Manner and content of Notification of Determination of Review or Appeal

a. The Claims Fiduciary will provide a written or electronic notification of the determination on review. It an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such information is available free of charge upon request;

b. If the adverse determination is based on a medical necessity or Experimental, Investigational or Unproven treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment of the determination applying the terms of the Retiree Health Program to the Claimant's medical circumstances or a statement that such explanation is available free of charge upon request.

14.05 Claims Under HMO

In the event a claim is brought under an HMO, the HMO assumes the full responsibility for adjudicating the claim.

ARTICLE XV

Termination or Amendment

15.01 Termination or Amendment

The Company reserves the right in its absolute discretion, at any time and from time to time by action of its Board of Trustees or pursuant to authority granted by its Board of Trustees, to amend, modify or terminate the Retiree Health Program in whole or in part or to reduce, cease or increase the Company's and/or any Employer's contributions to the Retiree Health Program. Pursuant to authority granted by the Board of Trustees, the Plan Administrator shall have the authority to amend the Retiree Health Program, including the HMO Option, as he/she deems appropriate to facilitate the administration of the Retiree Health Program, including the HMO Option. No such amendment, modification, termination or change in Employer contributions shall retroactively affect adversely any Participants, Surviving Spouse's, Spouse's or Dependent Child's already incurred benefits under the Retiree Health Program.

The company reserves the right in its absolute discretion at any time and from time to time and without prior notice to participants, to amend, modify or terminate in whole or in part the retiree health Retiree Health Program set forth in this appendix I, and to reduce, cease or increase its contributions to the trust fund for the Retiree Health Program.

ARTICLE XVI

HIPAA Compliance

16.01 Use and Disclosure of Protected Health Information - In General

The Retiree Health Program will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the HIPAA. Specifically, the Retiree Health Program will use and disclose PHI for purposes related to health care treatment ("Treatment"), payment for health care ("Payment") and health care operations, ("Operations" and in the aggregate "TPO Purposes").

16.02 Use and Disclosure for Payment Purposes

Payment means activities undertaken by the Retiree Health Program to obtain premiums, determine or fulfill its responsibility for coverage or to provide reimbursement for the provision of plan benefits that relate to the Retiree, Covered Dependent or Eligible Retiree to whom health care is provided. These activities include, but are not limited to the following:

i. determination of eligibility, coverage, coordination of benefits and cost-sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a claim);
ii. adjudication and/or subrogation of health benefit claims (including appeals and other payment disputes);
iii. establishing Retiree contributions;
iv. risk adjusting amounts due based on enrollee health status and demographic characteristics;
v. billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance); related health care date processing;
vi. medical necessity reviews or reviews of appropriateness of care or justification of charges;
vii. utilization review, including precertification, preauthorization, concurrent review and retrospective review;
viii. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

16.03 Use and Disclosure for Operations Purposes

Operations means, but is not limited to, the following health care related activities:

i. quality assessment and improvement activities, including outcomes, evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

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

iii. reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

iv. underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

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

vi. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Program, including formulary development and administration, development or improvement of payment methods or coverage policies;

vii. business management and general administrative activities of the Program, including, but not limited to: management activities relating to implementation of and compliance with HIPAA's administrative simplification requirements; customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor or customer; resolution of internal grievances; the sale, transfer, merger or consolidation of all or part of the Retiree Health Program with another covered entity

or an entity that followed such activity will become a covered entity and due diligence related to such activity; and creating de-identified health information or a limited data set and fund raising for the benefit of the Program.

16.04 Use and Disclosure as Required by Law and as Permitted by the Retiree

With an authorization, the Retiree Health Program will disclose PHI to the Employers and each of the employee health, welfare and pension plans maintained or sponsored by CECONY or O&R for the purposes related to TPO activities of these plans.

16.05 Consolidated Edison Company of New York, Inc. - Plan Sponsor

The Retiree Health Program will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions:

i. not use or further disclose PHI other than as permitted or required by the Retiree Health Program document or as required by law;
ii. ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Retiree Health Program agree to the same restrictions and conditions that apply to the Plan Sponsor;
iii. not use or disclose PHI for employment-related actions and decisions;
iv. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor;
v. report to the Retiree Health Program any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
vi. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA privacy requirements;
vii. make available the information required to provide an accounting of disclosures;
viii. make internal practices, books and records relating to the use and disclosure of PHI received from Retiree Health Program available to determine compliance with HIPAA; and
ix. if feasible, return or destroy all PHI received from the Retiree Health Program that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed

for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

16.06 Adequate Separation Between the Plan and the Plan Sponsor

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI: the Employee Benefits Manager; and the staff members designated by the Employee Benefits Manager. The persons described in this Subsection may only have access to and use and disclose PHI for TPO functions that the Plan Sponsor performs for the Program.

16.07 Protection of Electronic Protected Health Information

In addition to the privacy conditions for disclosure of PHI, effective as of April 20, 2005, with respect to any electronic PHI disclosed to the Plan Sponsor by the Plan (or by a health insurance issuer or HMO with respect to the Plan), the Plan Sponsor will:

i. implement administrative, physical, and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Retiree Health Program as required by the HIPAA Regulations;

ii. ensure that any agents, including subcontractors, to whom it provides electronic PHI received from, or created or received by the Program, agree to implement reasonable and appropriate safeguards to protect the Retiree Health Program 's electronic PHI;

iii. report to the Retiree Health Program any security incidents of which it becomes aware. For this purpose a security shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system and such other incidents as shall be identified in the HIPAA Regulations from time to time; and

iv. ensure that adequate separation between the Retiree Health Program and Plan Sponsor required in 45 CFR §164.504 (f)(2)(iii) is supported by reasonable and appropriate security measures.

The Retiree Health Program (or a health insurance issuer or HMO with respect to the Program) will disclose electronic PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Retiree Health Program

has been amended to incorporate the provisions of 45 CFR §164.314 (b)(2), and the Plan Sponsor agrees to the conditions of disclosure set forth above in this paragraph.

ARTICLE XVII

Retiree Drug Subsidy and Prescription Drug Plan
Effective January 2006

17.01 General Provisions

The Prescription Drug Plan will submit an application to the CMS to participate in the Retiree Drug Subsidy program for those Plan Years in which the Prescription Drug Plan coverage is at least be equal to the standard prescription drug coverage under Part D that has a deductible equal in 2006 to $250 (adjusted for inflation). The Prescription Drug Plan will provide a co-insurance of 25% or an actuarially equivalent benefit to a benefit with 25% co-insurance for prescriptions after the deductible is satisfied and up to $2,250.

17.02 Maintain Records

The Prescription Drug Plan will maintain records so that the Secretary of Health and Human Services may audit those records and conduct oversight, including reviewing all contracts, financial statements and records regarding the prescription drug plans. Specific records will be retained for six years after the expiration of the Plan Year in which the costs were incurred for oversights and audits. The records that must be retained are:

a. Reports and working documents of the actuaries who wrote the attestation of actuarial equivalence of the benefits; and

b. All documentation of costs incurred and other relevant information used in calculating the amount of the subsidy payment, including the underlying claims data and any other records specified by CMS.

17.03 Requirements for Prescription Drug Plan to Qualify for the Subsidy

In order for the Prescription Drug Plan to qualify for the RDS subsidy, all of the following requirements must be met:

a. First, the Prescription Drug Plan must have an actuarial attestation that meets the requirements below.

b. Second, all Part D Medicare Eligible Participants covered under the plan must be provided with creditable coverage notice.

c. Third, records must be maintained and made available for audit as described below.

d. Fourth, the plan sponsor must have a written agreement with the health plan regarding disclosure of information to CMS and the plan must disclose to CMS on behalf of the sponsor the information that is necessary for the sponsor to comply with the Medicare prescription drug regulation.

e. Fifth, the plan sponsor must submit a signed application for the subsidy to CMS with the employer's tax identification number, the sponsor's name and address, an actuarial attestation that meets CMS's standards and any required supporting documents, a signed sponsor agreement, other CMS specified information, and either a list of all persons the plan sponsor believes are qualifying covered retirees under the plan sponsor's plan and who are not enrolled in Medicare Part D with each person's full name, health insurance claim number or Social Security number, date of birth, gender, relationship to retired employee, or the plan sponsor may enter into a voluntary data sharing agreement with CMS.

17.04 Creditable Coverage

Under Part D of the MMA, the Retiree Health Program must disclose whether the Prescription Drug Plan is "creditable prescription drug coverage" ("Disclosure Notice") in accordance with the following rules:

a. The Retiree Health Program must disclose to CMS whether the Prescription Drug Plan coverage is creditable or non-creditable on an annual basis and upon any change that affects whether the coverage is creditable.

b. The Disclosure Notice must be provided to all Medicare Eligible Participants who are covered under, or who apply for, coverage under the Prescription Drug Plan. The Disclosure Notice requirement applies with respect to a Medicare Eligible Participant who is an active employee, disabled, on COBRA, and a Medicare Eligible Participant who is covered as a spouse or dependent (including those spouses or dependents that may be disabled or on COBRA) under active employee coverage

c. A Disclosure Notice may but is not required to be sent as a separate mailing and may be provided with other information materials (including enrollment and/or renewal materials). The Retiree Health Program may provide a single Disclosure Notice to all Medicare Eligible Participants covered under the Retiree Health Program. A Disclosure Notice may be provided electronically if the Medicare Eligible Participant has indicated

that s/he has adequate access to electronic information. Before a Medicare Eligible Participant agrees to receive information via electronic means, s/he must be informed of her/his right to obtain a paper version, how to withdraw consent, how to update address information, and be advised of any hardware or software requirements needed to access and retain the creditable coverage disclosure.

d. Notice Disclosure must be made at the following times:

i. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) – beginning November 15th through December 31st of each year;
ii. Prior to an individual's Initial Enrollment Period (IEP) for Part D;
iii. Prior to the effective date of coverage for any Medicare Eligible Participant that joins the Prescription Drug Plan;
iv. Whenever the Retiree Health Plan no longer offers prescription drug coverage or changes the coverage offered so that the Prescription Drug Plan is no longer creditable; and
v. Upon a beneficiary's request.

e. If the creditable coverage disclosure notice is provided to all Plan Participants annually, CMS will consider items d. i. and d. ii. to be met.

ARTICLE XVIII

General Provisions

18.01 General Provisions

If the Named Fiduciary finds that any person to whom any amount is payable under the Retiree Health Program is unable to care for his or her affairs because of illness or accident, or is a minor, or has died, then any payment due him or her or his or her estate (unless a prior claim therefore has been made by a duly appointed legal representative) may if the Plan Administrator so elects, be paid to a Spouse, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall be a complete discharge of the liability of the Employers, and the Program.

The Retiree Health Program and all rights there under shall be governed by and construed in accordance with the laws of the State of New York and all applicable Federal laws and regulations.

Consolidated Edison Company of New York, Inc.
Statement Of Privacy Polices And Practices
Effective April 14, 2003

Statement of Privacy Policy

Consolidated Edison Company of New York, Inc. is the Plan Sponsor of The Consolidated Edison Inc. Master Health Plans For Eligible Retirees Of Consolidated Edison Company Of New York, Inc., Orange And Rockland Utilities, Inc. and Certain Affiliates Of Consolidated Edison, Inc. and The Consolidated Edison Program (the "Plans"). The Plan Sponsor, Employers and the Plans are committed to protecting confidential and protected health information they collect from or receive about employees. It is the intention of the Plan Sponsor, Employers and the Plans to take all steps required to ensure that this privacy policy be maintained in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, and the Privacy Regulations as promulgated by the U.S. Department of Health and Human Services.

The Plan Sponsor has amended the terms of the Plans to provide for a complete explanation of the Privacy Policy of the Plan Sponsor. The Plan Sponsor, Employers and the Plans are committed to abide by these procedures.

The Plan Sponsor, Employers and the Plans specifically reserve the right to amend, alter, change and/or terminate any of these procedures as become necessary to comply with the law.

Privacy Practices

1. Designation of Privacy Official

The Plan Sponsor has designated an individual as a Privacy Official for the purposes of implementing the Privacy Practices. This individual is responsible for developing, implementing and maintaining these practices and for amending these practices as necessary. Included in the function of the Privacy Official are: tracking all protected health information; setting up structures to ensure individual rights; auditing and monitoring privacy practices; and coordinating other employer functions.

At this time, Hector Reyes, Director, Employee Benefits, has been designated as the Privacy Official.

2. Designation of Contact Person

The Contact Person for the Plans is that individual responsible for receiving complaints about any failure of the Plans or the Plan Sponsor or Employers to comply with any of the policies or procedures developed by the Plans or for any violations of the privacy rules in general. This person is able to provide information concerning the practices of the Plans. At this time, the Plans have designated Nancy Shannon for the CECONY Plans as the Contact Persons. Liz O'Halloran has been designated as the contact person for the plans sponsored by Orange and Rockland Utilities, Inc.

3. Privacy Training Programs

All employees of the Plan Sponsor and Employers that perform work for the Plans are required to receive training in the privacy practices and policies and the operation of the Plans. Any new employee who will have contact with protected health information is required to receive training prior to commencing work for the Plans. The goals of training are to inform employees about the technical and practical requirements of compliance with the privacy regulations and this policy. Ongoing training will be conducted as becomes necessary to ensure compliance with any changes to the law or this policy.

4. Internal Complaint Process

he Plans have established a mechanism for dealing with complaints received in accordance with the instructions given in the Privacy Notice as issued to all employees. Pursuant to that notice, complaints from individuals are to be directed to the Privacy Official.

The Privacy Official shall receive and log receipt of any complaints. Upon receipt of the complaint, the Privacy Official shall conduct an investigation to determine the accuracy of the complaint and the extent to which any privacy rights of the individual have been violated. The investigation is to be completed within 30 days after receipt of the complaint.

Once the investigation is completed, the Privacy Official shall act to correct any procedures or actions that created the basis for the complaint. The Privacy Official shall take all reasonable steps necessary to correct any breach of privacy identified, including amendment or adjustment to this policy or any internal practices that gave rise to the breach. The Privacy Official shall notify the

complaining individual within 60 days of receipt of the complaint of the results of the investigation and the resolution of the problem.

The Privacy Official shall maintain a log of all complaints, made either in writing or orally, together with an accounting of the resolution of the complaint. All complaint resolution functions are to be completed by the Privacy Official.

In the event that the Privacy Official determines that the breach of privacy practices occurred as a result of the actions of a Plans' employee, or other employee of the Plan Sponsor or Employer, the Privacy Official shall have authority to sanction that employee. Sanctions can range from verbal reprimand to temporary loss of privileges for access of information.

5. Data Security

The Plans and the Plan Sponsor are jointly developing procedures for ensuring the security of protected health information.

6. Documenting Uses and Disclosures

Protected health information will be stored separate from all other files. Protected health information is not stored or maintained in individual employee personnel files. All protected health information obtained by the Plans or the Plan Sponsor or Employers is to be viewed only by the Privacy Official or other such Plans employee who has been trained in these privacy procedures. No other employee shall be permitted to view protected health information.

The Privacy Official and the employees of the Plans shall maintain logs of receipt, viewing or other such use of protected health information. The Privacy Official shall maintain these logs for the purpose of providing a record of all uses of protected health information. Disclosures of health information shall be referenced in the log. The logs shall be kept and maintained for a period of six (6) years.

7. Inspecting and Copying Records

Individuals covered by the Plans are granted access to the designated record set of the Plans. The designated record set is that information pertaining to enrollment, claims adjudication, claims payment, appeals, appeal determinations, case management summaries or other such information used by the Plans to administer claims. This designated record set is maintained separate from all other employment or personnel records.

Individuals seeking access to information contained in the designated record set must make such a request in writing to the Plans. The Privacy Official shall respond to the request within 30 days of its receipt. Receipt of requests and inspection of health information is to be recorded on the disclosure log maintained by the Plans. Individuals seeking copies of a designated record set shall be charged $.25 per page for copying costs, plus postage if a mailing of the information is requested. Inspections without copying must be completed in-person by the individual requesting the information and will be done in a private office at the Plan Sponsor headquarters. The original of the designated record set shall not be removed from the Plan Sponsor headquarters.

If a request for access to the designated record set is denied, the Privacy Official shall notify the individual of the denial within 30 days of the original request and shall permit the individual to appeal the denial of access.

8. Amending and Correcting Medical Data

Individuals are given the right to amend or correct protected health information maintained by the Plans in the designated record set. Individuals seeking to amend or change information must submit the request in writing on a form provided by the Plans. The Privacy Official shall then review the request to determine if amendment is permitted. The Privacy Official shall respond to the request within 30 days from the date of receipt of the request.

All requests for amendment shall be maintained and recorded as receive in the log established by the Plans. If the request is denied, the individual shall be notified of the decision within 30 days of the date of receipt of the initial request and shall be permitted the opportunity to appeal the denial. Appeals shall be determined by the Privacy Official.

If the amendment is approved, the Privacy Official shall document the change in the designated record set and shall ensure that all future disclosures of protected health information evidence the change.

9. Retained Documents

The Privacy Official, on behalf of the Plans, Plan Sponsor and Employers will retain and make available (where appropriate) the following documents: plans documents and summary plans descriptions; the privacy policy and procedure summary; all signed privacy authorizations; the plans privacy notice; designated record sets; requests for inspection and copying; requests for amendments to

health information; authorizations to release information; all logs and records of disclosure; all complaints and resolutions; business associates contracts and the Company's certification.

These records shall be maintained in a location specified for use by the Plans only at the Plan Sponsor's headquarters. Access to these documents shall be restricted to Plans employees and to those individuals designated by the Privacy Official as having appropriate access. Copies of all documents and records shall be provided by the Privacy Official upon request, in accordance with this policy, and as required by applicable law.

10. Revising Privacy Policies and Practices

The Plan Sponsor, Employers and the Plans shall revise these privacy policies and practices, through the direction of the Privacy Official, as is necessary to comply with the law. Policies and Procedures may be amended or adapted to fit the needs of the Plans. If necessary, the Plans will reissue privacy notices to covered individuals to alert them of significant changes.

All changes to policies and practices will be amended prospectively only and shall be documented through amendment to this Privacy Policy Statement. An original of this statement shall be maintained.

11. Employers Adopting the Privacy Policy Statement

Effective as of April 14, 2003, the Employers adopting this Privacy Policy Statement include Consolidated Edison Company of New York, Inc., Orange and Rockland Utilities, Inc., Consolidated Edison Solutions, Inc., Consolidated Edison Development, Inc., Consolidated Edison Communications, Inc., and Consolidated Edison Energy, Inc..

12. Employers Adopting the Electronic PHI Security Standards

Effective as of April 20, 2005, the Plan Sponsor, Employers and Plans adopted the terms, conditions, and standards required in the HIPAA Electronic Protected Health Information, as set forth in Article 10.08 of the Retiree Health Program.