

The Consolidated Edison Retiree Health Program



Understanding Your Health Care Benefits

A SUMMARY PLAN DESCRIPTION

**The Summary Plan Description of
the Con Edison, Inc. Retiree Health
Program
for
Eligible CECONY Retirees,
Eligible O&R Management Retirees,
&
Eligible O&R Local 503 Retirees
&
their Eligible Covered Dependents**

Effective January 1, 2013

INTRODUCTION

This booklet, called the Summary Plan Description or SPD, describes the health care benefits that are available to eligible retirees of Consolidated Edison Company of New York, Inc. (CECONY) and their eligible dependents and eligible retirees of Orange and Rockland Utilities, Inc. (“O&R”) and their eligible dependents under the Consolidated Edison, Inc. Retiree Health Program. In addition, certain affiliates of Consolidated Edison, Inc. (CEI) may have adopted the Program for some of their retirees (CEI Affiliates).

GROUPS

There are three different groups covered including the CECONY Retirees, O&R Management Retirees, and O&R Local 503 Retirees. Unless there is a difference between the O&R Management Retirees and the O&R Local 503 Retirees, the term O&R Retirees applies to both. Unless there is a difference under the Retiree Health Program for any particular group, the term “Retiree” or “you” applies to all Retirees.

EMPLOYERS, COMPANY, AND EFFECTIVE DATE

Throughout this Summary Plan Description (“SPD”), CECONY, O&R, and each CEI Affiliate that has adopted the Retiree Health Program, is referred to as an Employer. The Company is CECONY. The effective date of this SPD is January 1, 2013. The SPD is required under the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SPD replaces the SPD dated July 2003, and the supplements – referred to as summaries of material modifications – to that SPD.

Although the Company currently sponsors the Retiree Health Program, neither the Company nor an Employer has an obligation to anyone, including but not limited to each employee, retiree, surviving spouse, or any other Participant including a Participant who has been covered under the Retiree Health Program under any special arrangement, contract, or settlement, to continue the Retiree Health Program for any fixed period of time or throughout the duration of a Participant's lifetime. The Company and each Employer reserve the right to change or terminate the Retiree Health Program, in whole or in part, at any time and for any or no reason.

Each participating Retiree, surviving spouse and all other Participants in the Retiree Health Program are responsible for the full cost of the Retiree Health Program except to the extent that your Employer elects to pay a part of the cost. Although your Employer may elect to pay part of the cost in future years, neither the Company nor any Employer is committed to contribute any fixed amount or percentage of the costs.

SDP AVAILABLE ELECTRONICALLY

If you are receiving this SPD electronically, you have the right to request and receive a paper copy by contacting HR Service Center at 1-800-582-5056 for CECONY Retirees and O&R Benefits Department at 1-800-577-9527 for O&R Retirees. We urge you to read this SPD carefully and keep it for future reference. The SPD is published in full on the intranet web sites of Con Edison and O&R under Benefits as well as Con Edison's web site www.coned.com under quick links Retirees Web Site. Updates, referred to as summaries of material modification (SMM), are also published on the intranet websites for Retirees of Con Edison and O&R as well as Con Edison's web site www.coned.com and under quick links Retirees Web Site. For O&R it is www.retirees.oru.com.

Under ERISA, the electronic disclosure rules permit the Plan Administrator to use an electronic communication network, such as your Employer's intranet site or internet site, to provide a copy of the SPD to any Participant who has the ability to effectively access documents furnished on the intranet or internet. The Plan Administrator has chosen to use an electronic communication network as often as legally permissible. This means that the Plan Administrator will use electronic communications to disclose to each retiree and Participant who has affirmatively consented or confirmed consent electronically, and has provided an address for the receipt of electronically furnished documents. The Plan Administrator may use the intranet and internet websites and e-mail for distributing the SPD. By publishing the SPD on your Employer's intranet and internet website, the Plan Administrator is fulfilling her disclosure obligations to each individual who meets these conditions. However, you always have the right to request a paper copy. Paper copies will be made available and provided to those Participants for whom electronic disclosure is not available or accessible.

The Retiree Health Plan and the Prescription Drug Plan are self-insured by your Employer. The third party administrators provide claim administration services but do not insure the benefits described.

In the event there is a difference between the information in this SPD and the information in the Plan Document, the information in the Plan Document is controlling.

A. PART I -- Highlights of Some of the Changes to the Retiree Health Program Since The Last Summary Plan Document

1. The Retiree Health Program is Not Subject to Most of the Affordable Care Act Mandates

The Con Edison Retiree Health Program is designed as and operated to be a “retiree- only” health plan. This means that the Retiree Health Program is not required to comply with the Patient Protection and Affordable Care Act (“Affordable Care Act”) and is not subject to mandates under the Affordable Care Act. For example, the Retiree Health Program does not and will not cover adult children, does not and will not comply with the rules about preventive care, and does not and will not lift lifetime limits in coverage.

2. New Prescription Drug Plan for Each Participant Who Is Medicare Eligible

Effective January 1, 2013, the Prescription Drug Plan began coordinating with a Group Medicare Part D prescription drug program (PDP). Each Retiree who is eligible for Medicare will have his or her coverage provided by SilverScript as an Employer PDP. This plan is offered by SilverScript, an affiliate of CVS Caremark, and is a Group Medicare Part D prescription drug plan provider.

3. Same-Sex Spousal Coverage

Effective January 1, 2012, two changes were made affecting the coverage of same-sex partners. The first change is that your same-sex domestic partner is no longer an eligible dependent, and domestic partner benefits were eliminated. The second change is that your same-sex spouse is now included in the definition of spouse. This means that, beginning January 1, 2012, you must be married to cover your same-sex partner.

4. Cash Balance Pension Formula Retirees

Employees who are covered under the Cash Balance Pension Formula in the Consolidated Edison Retirement Plan, and retire after January 1, 2013, and otherwise meet the eligibility requirements for the Retiree Health Program, will be required to pay the full cost of the coverage.

5. O&R Management Participant Covered Under the Career Average Pension Formula

Effective January 1, 2014, for all O&R Management Retirees and Participants, under the cost-sharing formula, O&R will “cap” its contribution for retiree health costs to the preceding year’s cost plus inflation measured by the change in the Consumer Price Index (“CPI”). Each O&R Management Retiree who is covered under the Career Average Pension Formula will pay 100 percent of the remaining cost of the coverage.

6. Local 503 Employee

If you are an O&R Local 503 employee covered under the Career Average Pension Formula and you retire before January 1, 2015, you will contribute the same amount toward your health care as an active employee until you reach age 65. At age 65, you will no longer have a contribution to your health care plan.

If you are an O&R Local 503 employee covered under the Career Average Pension Formula or the Cash Balance Pension Formula, and retire on or after January 1, 2015, you will contribute an amount toward your health care, whether you are under or over age 65, subject to the applicable Schedule of Benefits.

Each Local 503 employee covered under the Defined Contribution Pension Formula hired on or after January 1, 2015, will contribute 50% toward the cost of his or her retiree health plan benefits.

7. Employer/Company Contributions

CECONY Contribution Methodology is Adopted by O&R

Beginning In January 2008, CECONY’s annual contribution, if any, is the maximum amount of the previous year’s contribution for CECONY, plus a cost of living adjustment. The cost of living adjustment is based on the change in the Consumer Price Index (CPI). If CECONY costs for CECONY Retirees are projected to increase above the cost of living adjustment, CECONY’s contribution will not be enough to cover the rise in costs, and CECONY Retirees’ monthly contribution is increased.

Beginning in January 2014, if you were actively employed as a management employee of O&R and covered under the Career Average Pension Formula in the Consolidated Edison Retirement Plan, there will be a limit to the amount O&R contributes to the cost of your Retiree Health coverage, which reflects the same contribution approach as CECONY. Each year, beginning in 2014, O&R's contribution to the Retiree Health Program will be the same amount as in the previous year, plus a cost-of-living adjustment based on the change in the Consumer Price Index (CPI). If health care costs rise above the CPI, O&R Management Retirees' monthly contributions will be increased.

B. PART II -- The Retiree Health Program-- Summary of Structure

1. For Coverage of Hospital and Medical Only:

- a. **For an individual eligible for Medicare** – The Retiree Health Plan is a supplemental medical plan administered by a third party administrator. The Employers and the Company have reserved the right to change third party administrators, from time to time, and in their discretion. In general, Medicare is responsible for determining what is covered and the amount covered. If you are a CECONY Retiree, rather than the Medicare supplemental plan, you may elect a Health Maintenance Organization (HMO) option. If you are an O&R Retiree, you may not choose an HMO option.
- b. **For an individual not eligible for Medicare** – The Retiree Health Plan is an Open Access Plus Plan (“OAP”) administered by a third party administrator which currently is Cigna. The OAP is available to each individual who is under age 65 and not eligible for Medicare. If you are a CECONY Retiree, rather than the OAP, you may elect an HMO option. If you are an O&R Retiree, you may not choose an HMO.

2. For Coverage of Prescription Drug Benefits Only

- a. **For an individual eligible for Medicare** – The Retiree Health Plan offers a Group Medicare Part D prescription drug plan that is administered by

SilverScript and available only if you are eligible for Medicare. If you are a CECONY Retiree and you elected an HMO option, you may not elect the Prescription Drug Plan. Your prescription drug coverage will be available through the HMO.

- b. **For an individual not eligible for Medicare** - The Retiree Health Program offers a separate prescription drug benefit plan that is administered by a third party administrator, which currently is CVS Caremark, and referred to as the Prescription Drug Plan. The Prescription Drug Plan is available to each individual who is under age 65 and non-Medicare eligible.

3. Dental benefits are not covered under the Retiree Health Program.

C. PART III -- Eligibility Rules and Requirements

1. Who is Eligible

a. CECONY Retiree

If you are a CECONY Retiree, you are eligible to participate in the Retiree Health Program if, on the day immediately preceding the date you terminate employment with CECONY, you meet each one of the following requirements:

- i. you are actively employed, and
- ii. you are a participant in the Consolidated Edison Retirement Plan (Retirement Plan), and
- iii. you have at least 75 Points, as that term is defined and explained in the Retirement Plan, on the day of or immediately before you terminate employment (Rule of 75 Pension). Unlike the rules under the Consolidated Edison Retirement Plan, if you do not have 75 Points when you terminate, you do not and cannot “grow” into your 75 Points for purposes of meeting the eligibility requirements under the Retiree Health Program.
- iv. If you terminate employment directly from CECONY because of a total and permanent disability, you are eligible to participate in the Retiree Health Program if you meet each one of the following requirements: you have reached age 50, and as of the date of your termination from active employment, you have at least 20 years of accredited service, as that term

is defined in the Retirement Plan, and you are a Participant in the Retirement Plan.

- v. Effective on and after January 1, 2013, if (1) because of a total and permanent disability, (2) without any break in time or service, (3) you immediately become entitled for benefits under the long term disability plan sponsored by CECONY, and (4) you are credited with at least 75 Points within the first 6 months on long term disability, you will become eligible to participate in the Retiree Health Program.

b. CECONY Transferred Employee

If you are a former employee of CECONY and, without any break in employment, you directly transferred employment to a CEI Affiliate, you are eligible to participate in the Retiree Health Program so long as you otherwise satisfy the same requirements and conditions for a CECONY Retiree. However, you must confirm with you CEI Affiliate Employer that your CEI Affiliate Employer has affirmatively elected to be a Participating Employer. Not every CEI Affiliate has adopted the Retiree Health Program.

c. O&R Retiree

If you are a retiree of O&R, you are eligible to participate in the Retiree Health Program if, on the day immediately preceding the date you terminate employment with O&R:

- i. you are actively employed,
- ii. you are a Participant in the Retirement Plan, and
- iii. you have attained age 55 and have at least 10 years of service, as that term is defined and explained in the Retirement Plan, on the day of or immediately before you terminate employment .
- iv. if you are an O&R Local 503 employee, as of January 1, 2015, you must have attained age 55 and have at least 20 years of service.
- v. If you terminate employment from O&R and you meet the requirements for a Disability Retirement under the Retirement Plan, you are eligible to participate in the Retiree Health Program.

2. Who is an Eligible Dependent

Your eligible spouse, your eligible surviving spouse, and your eligible child dependent may each be an Eligible Dependent as long as certain requirements are met and certain conditions are satisfied.

a. Requirements and conditions for an Eligible Dependent

As a retiree-only plan, the Retiree Health Program does not cover an active employee of an Employer who is covered under the active health plan for employees of CECONY or O&R – called the Consolidated Edison Master Health Plan (the “Master Health Plan”).

If a spouse or child is covered under the Master Health Plan, so long as he or she is covered under the Master Health Plan, he or she cannot be covered under this Retiree Health Program.

A “Surviving Spouse” of a Retiree is eligible to continue being an Eligible Dependent and covered under the Retiree Health Program following the death of the Retiree if he or she is receiving a Surviving Spouse’s pension benefit from the Retirement Plan.

Effective January 1, 2014, a spouse of an O&R Retiree who was covered before the death of the O&R Retiree may continue coverage whether he or she is receiving a pension benefit from the Retirement Plan.

A legally married spouse may not concurrently be eligible to be a Surviving Spouse.

A surviving spouse is the same person who is legally married to the Retiree on the date the Retiree’s begins his or her Pension and on the date of the death of the Retiree. The Surviving Spouse also has had to be covered on the date of death of the Retiree.

A Retiree who marries or re-marries after his or her pension allowance begins and after coverage has begun under the Retiree Health Program may cover his or her newly acquired spouse. The Retiree’s newly acquired spouse is not eligible to continue his or her participation in the Retiree Health Program when the Retiree dies. A newly acquired spouse is never

treated as a Surviving Spouse under the Retiree Health Program. This provision does not apply to an O&R Local 503 Retiree.

A Retiree's or Surviving Spouse's unmarried dependent children are eligible until the end of the calendar year in which the child reaches age 19. If the child is a full-time student, the child may continue to be an Eligible Dependent until the end of the month in which the child reaches age 23. The Retiree Health Program is not subject to the Affordable Care Act mandates and is not required to cover and does not cover children until the age of 26.

The CECONY Retiree's surviving Covered Dependent Child(ren) continues to be eligible for coverage only if the Retiree's Surviving Spouse is receiving a pension benefit from the Retirement Plan.

The O&R Retiree's surviving Covered Dependent Child(ren) are covered only if he or she was covered at the date of death of the O&R retiree. The dependent children of a newly acquired spouse of an O&R Retiree are not eligible to continue to participate.

If a Retiree marries or acquires an Eligible Dependent child after becoming covered under the Retiree Health Program, the newly acquired spouse and/or dependent child are eligible for coverage as long as the Retiree remains a covered Participant.

An Eligible Dependent child includes a legally adopted child, a child placed in the household in anticipation of being legally adopted, a stepchild of a Retiree or Surviving Spouse, or a child living with a Retiree or Surviving Spouse if the Retiree or Surviving Spouse is the child's legal guardian. Each Employer requires proof of a child's dependent status before approving coverage.

If a Surviving Spouse remarries, neither the Surviving Spouse or his or her spouse is eligible to participate. Also, if a Surviving Spouse acquires an eligible dependent child, the child is not eligible to participate.

A CECONY Retiree's or Surviving Spouse's unmarried disabled dependent child is an Eligible Dependent, if the child becomes physically or mentally

incapable of self-support either before age 23 or in the case of an O&R Retiree, at any age, and while covered under the Master Health Plan or while he or she is a participant in the Retiree Health Program.

To continue coverage for a disabled child after the date when coverage would have ended under the Master Health Plan in the month immediately before attainment of age 26, you must send proof of your child's incapacity within 31 days after coverage would otherwise end. Additional proof may be required from time to time.

b. **If your spouse or dependent child is actively employed at a Con Edison company –important rules**

If, when you terminate employment from CECONY, or O&R, or a participating CEI Affiliate Employer, your spouse is an active employee of a CEI Company and he or she is covered under the Master Health Plan, you may be covered as his or her dependent spouse under the Master Health Plan until he or she terminates employment. Your eligibility date will then be the first day of the month immediately following the last day of the month that you are covered under the Master Health Plan.

If, when your spouse terminates employment, he or she independently satisfies the Retiree Health Program requirements, you and your spouse are both then eligible to enroll in the Retiree Health Program. However, if your spouse is not eligible to independently qualify for participation under the Retiree Health Program, you may enroll yourself as a Retiree with your spouse as your covered eligible dependent.

If your dependent child is actively employed at a CEI Company, and is eligible to (whether he or she actually does) participate in the Master Health Plan, he or she cannot participate in the Retiree Health Program.

The Retiree Health Program does not and cannot cover an actively employed employee.

D. PART IV -- Eligibility Dates, Enrollment and Coverage Dates

1. Eligibility Date for a CECONY or CECONY Transferred Retiree

Once you satisfy the eligibility requirements, you must elect to participate on your eligibility date. If you do not elect to participate on your Eligibility Date, you will no longer be eligible to participate.

It is your responsibility to notify your Employer when you are first eligible to participate. Participation is not automatic and you must make your affirmative elections. If you do not take action on your eligibility date, and you are not covered by an exception, you will forever lose the right to elect coverage in the future. Unless you meet an explicit exception, referred to below, you cannot waive coverage in one year and elect coverage in the next year.

In most instances, your eligibility date is the first day you satisfy the eligibility requirements which, in general, is the day you terminate or retire from employment and are eligible to elect to receive an immediate distribution of your pension. This is the case even if an immediate distribution of your pension is discounted to take into account the early distribution date.

You are no longer eligible to participate in the Retiree Health Program and you lose forever your right to elect coverage if, when you terminate or retire, you defer receiving your Pension until a later date unless you are covered by the exception. This is the case even if you defer your pension benefit for purposes of growing into certain subsidiaries in the Retirement Plan or for any other reason.

2. Exceptions to the Rule that You Must Participate When First Eligible for a CECONY or CECONY Transferred Retiree

Exception One: You may delay the date beyond your eligibility date **if, and only if,** (1) you have other employer provided group coverage or qualified health plan coverage sponsored by a Federal or State marketplace exchange, **and** (2) you have had no break in coverage. See the rules below.

Exception Two: If you satisfy the requirements for a disability pension but defer commencement of your disability pension, you may be eligible in the future to join the Retiree Health Program.

3. Eligibility Date for an O&R Retiree:

Once you satisfy the eligibility requirements, you must elect to participate on your eligibility date. If you do not elect to participate on your eligibility date and waive coverage, you can elect coverage during any open enrollment provided you show proof you had continuous credible health care coverage prior to enrolling in the Retiree Health Plan. Participation is not automatic and you must make your affirmative elections. If you do not take action on your eligibility date, and you are not covered by an exception, you will forever lose the right to elect coverage in the future.

In most instances, your eligibility date is the first day you satisfy the eligibility requirements which, in general, is the day you terminate or retire from employment and are eligible to elect to receive an immediate distribution of your pension. This is the case even if an immediate distribution of your pension is discounted to take into account the early distribution date.

4. How Each Retiree Enrolls In the Retiree Health Program

You can complete an Enrollment Form for the Retiree Health Program during your retirement orientation meeting. The forms needed for enrolling are available online at www.coned.com under quick links Retirees web site. You must enroll within the 31-day period immediately following your eligibility date.

If you are an eligible retiree, and you elect to begin your pension benefit immediately following your termination of employment, and either you or both you and your spouse are covered under another employer's group hospital and medical plan or a Federal or State Exchange Plan, you or your spouse may delay enrollment in the Retiree Health Program during the normal 31-day period.

Your new mandatory eligibility date is the first of the month immediately following the last day of your other group health plan coverage. You must maintain coverage, without interruption under your other group plan, from the date you first become eligible for coverage under the Retiree Health Program until the date you want to elect into the Retiree Health Program. You may not have any break in group health care coverage.

If you or your spouse is affected by the exception to the 31-Day Rule and delay coverage, you and/or your spouse will be asked to provide proof of your continuous coverage – for example, a letter from the insurance carrier of your prior health plan or a certificate of credible coverage.

Retirees and their Eligible Dependents may enroll in the Retiree Health Plan even if they have pre-existing health conditions that might make them ineligible for other health plans. Enrollment in the HMO Option is open to CECONY Retirees and their eligible dependents except those who have end-stage renal disease or participate in a hospice program.

5. When Coverage Starts for each Retiree

Coverage under the active Master Health Plan does not automatically transfer to the Retiree Health Program. Providing you complete all the necessary forms, you pay the necessary contributions, and you have met all the requirements, you and your Eligible Dependents will be covered under the Retiree Health Program on the first day of the month immediately following the month in which you become an eligible Retiree. This is generally the first day of the month immediately following the month in which you retired.

You must complete and return a Retiree Health Program Enrollment Form authorizing your Employer to deduct any required plan contributions from your monthly pension benefit. If you are not receiving a monthly pension benefit for any period of time, you must make arrangements with your Employer to mail in your monthly contributions.

It is your obligation and responsibility to ensure that monthly payments are made timely. It is your obligation to enroll your Eligible Dependent(s) in the Retiree Health Program.

E. PART V -- General Information on Covered Expenses and Benefits Provided

The Retiree Health Program includes the Retiree Health Plan that has a separate design for individuals not eligible for Medicare (called the OAP) and for individuals eligible for Medicare (called the Medicare Supplemental Plan). The Retiree Health Plan provides hospital, medical and vision care services.

The Retiree Health Program includes an HMO Option for CECONY Retirees who are not eligible for Medicare and for CECONY Retirees who are eligible for Medicare.

The Retiree Health Program includes a Prescription Drug Plan that has a separate design for individuals not eligible for Medicare (called the Prescription Drug Plan) and for individuals eligible for Medicare (called the Group Medicare Part D Plan).

For a CECONY Retiree, the Retiree Health Plan is a separate plan from the Prescription Drug Plan and each can be separately elected. For an O&R Retiree, the Retiree Health Plan includes coverage under the Prescription Drug Plan and cannot be separately elected.

The Retiree Medical Plan and the Prescription Drug Plan are self-insured programs. The HMO Options are fully insured.

For CECONY Retirees, the Retiree Health Plan pays hospital, medical and vision care benefits up to a lifetime maximum of \$1.0 million for each person. For O&R Retirees, the lifetime maximum of \$1.0 million per person ends at age 65. After age 65, each O&R Retiree has a \$35,000 limit per person.

The Amount the Retiree Health Plan Pays

In general, the Retiree Health Plan pays the **Charges** for medically necessary covered services and supplies, in accordance with the applicable definition of Charge, as set forth below:

“**Charges**” in the OAP for an in-network provider or a participating provider means the pre-negotiated discount fee or pre-negotiated contract rate, as determined solely by the third-party administrator.

“**Charges**” in the OAP for an out-of-network provider or a non-participating provider means the Maximum Reimbursable Charge, as determined solely by the third-party administrator.

“**Charges**” under the Medicare Supplemental Plan means the Medicare Allowable Charge or the Medicare Reimbursable Amount, as determined by Medicare.

F. PART VI – Hospital, Other Health Care Facilities, and Other Inpatient Confinement

1. Rules Applied for In-patient Admissions Including Hospital and Other Health Care Facilities

Hospital and in-patient stays include the facility charge and other necessary covered services and supplies. For any day of hospital and/or in-patient confinement, covered services will not include that portion of charges which are more than the limits shown in the applicable Schedule of Benefits.

If Individual is Not Eligible For Medicare

If you or your Covered Eligible Dependent is utilizing an in-network provider, the in-network provider is responsible for pre-certifying the pre-admission certification and the continued stay review. Before scheduling any non-emergency treatment in a hospital, the in-network provider is responsible for requesting in writing a pre-admission certification. In the case of an emergency admission, the in-network provider will contact the third party administrator within 48 hours after the admission.

If you or your covered eligible dependent is utilizing an out-of-network provider, you or your covered eligible dependent is responsible for pre-certifying your pre-admission certification and continued stay review. If you or your covered eligible dependent is utilizing an out-of-network provider, before you schedule any non-emergency treatment in a hospital, you or your Covered Eligible Dependent is responsible for requesting in writing a Pre-Admission Certification. In the case of an emergency admission, you must contact the third party administrator within 48 hours after the admission. Before the end of the certified length of stay, contact the third party administrator.

Pre-admission certification and continued stay review refer to the process used to certify the medical necessity and length of a hospital confinement or in-patient admission at another health care facility. This includes an admission as a registered bed patient for a partial hospitalization for the treatment of mental health or substance abuse; and/or for mental health or substance abuse residential treatment services.

If you or your Covered Eligible Dependent is utilizing an out-of-network provider, and these rules are not followed, here are some of the potential consequences:

Unless pre-admission certification is received: (a) before the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission, then covered expenses incurred will result in a reduction of Charges made for each separate admission to the hospital.

- i. Covered expenses do not include, and the Retiree Health Plan will not pay for, hospital charges for bed and board for treatment that is, for any day(s) in excess of the number of days certified through pre admission certification or continued stay review.
- ii. covered expenses do not include, and the Retiree Health Plan will not pay for, any hospital charges for treatment for which pre- admission certification was requested, but which was not certified as medically necessary.

If Individual is Eligible For Medicare

Medicare coordinates and administers hospital and in-patient stays. You do not have to contact the third party administrator. Medicare provides for different rates of reimbursement based on the length of stay and applies the Medicare rules under the Medicare Supplemental Plan. The Medicare Supplemental Plan covers only those expenses covered under Medicare and assumes Medicare is primary. The Schedule of Benefits sets forth the limitations, costs, coverage, and other details.

2. In-patient Hospital and Other Health Care Facilities Deductible

If Individual is Not Eligible For Medicare

There is one annual calendar year per person deductible for in-patient care in a hospital, skilled nursing facility, convalescent facility, hospice, or other health care facility, whether in-network or out-of-network.

The annual deductible is based on your Group – CECONY Retiree, O&R Management Retiree, or O&R Local 503 Retiree. The deductible is subject to change.

If Individual is Eligible For Medicare

Under the Medicare Supplemental Plan, Medicare determines and controls whether and how much the annual deductible is for in-patient care. The Medicare

Supplemental Plan applies the Medicare rules; the Schedule of Benefits sets forth the limitations, costs, coverage, and other details.

3. In-patient Admissions - Covered Services

If Individual is Not Eligible For Medicare

Covered Services when there is an in-patient admission means the expenses incurred after you or your Eligible Dependent becomes covered under the Plan. Services are considered covered services only to the extent that such services or supplies provided are recommended by a physician and are **medically necessary**, as determined by the third party administrator. Co-payments, deductibles, limits, or maximums are detailed in the Schedule of Benefits. In-patient admission covered services **include** Charges:

- a. made by a hospital, on its own behalf, for facilities charges, and other necessary services and supply charges made by a hospital, on its own behalf, for medical care and treatment received as an outpatient;
- b. made by a free-standing surgical facility, on its own behalf for medical care and treatment;
- c. made on its own behalf, by another health care facility (which includes skilled nursing facilities, rehabilitation hospitals, or subacute facilities for medical care and treatment); except that for any day of other health care facility confinement, covered expenses will not include that portion of charges in excess of the other health care facility daily limit shown in the Schedule of Benefits;
- d. made for emergency services and urgent care;
- e. made by a physician or a psychologist for professional services;
- f. made by a nurse, other than a member of your family or your dependent's family, for professional nursing service;
- g. made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration;

- h. made for orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
 - i. the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
 - ii. the orthognathic surgery is medically necessary as a result of tumor, trauma, disease or;
 - iii. the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.
 - iv. repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review physician.

- i. Clinical trials may be covered if the charges are for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
 - i. the cancer clinical trial is listed on the NIH website www.clinicaltrials.gov as being sponsored by the federal government;
 - ii. the trial investigates a treatment for terminal cancer and:
 - A. (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;
 - B. the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
 - C. the trial is approved by the Institutional Review Board of the institution administering the treatment; and
 - D. coverage will not be extended to clinical trials conducted at non-participating facilities if a person is eligible to participate in a covered clinical trial from a participating provider.
 - iii. Routine patient services do not include, and reimbursement **will not** be provided for:
 - A. the investigational service or supply itself;
 - B. services or supplies listed as exclusions;

- C. services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);

If Individual is Eligible For Medicare

In-patient admissions covered services are only those charges covered and paid under Medicare. The plan assumes that Medicare is primary. Payment for the following is specifically excluded from this plan:

- a. Any expense or service or supply that is:
 - i. Not a Medicare Eligible Expense; or
 - ii. beyond the limits imposed by Medicare for such expense; or
 - iii. excluded by name or specific description by Medicare; except as specifically provided under the “Covered Expenses” section.

4. Non-Custodial Care in a Skilled Nursing Facility

If Individual is Not Eligible For Medicare

The Retiree Health Plan pays Charges for a semi-private room for non-custodial care in a skilled nursing facility approved by the third party administrator, and subject to limits as set forth in the Schedule of Benefits. To receive benefits, you 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. Services must be restorative.

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.

Your doctor must decide that you need daily skilled care given by, or under the direct supervision of, skilled nursing or rehabilitation staff. You get these skilled services in a skilled nursing facility that's certified by Medicare.

If Individual is Eligible For Medicare

Medicare determines what, whether, and how it will cover skilled services in a skilled nursing facility. Medicare requires your doctor to certify that you need skilled services for a medical condition that was either:

- a. A hospital-related medical condition.
- b. A condition that started while you were getting care in the skilled nursing facility for a hospital-related medical condition.

Your doctor may order observation services to help decide whether you need to be admitted to the hospital as an in-patient or can be discharged. During the time you're getting observation services in the hospital, you're considered an outpatient—you cannot count this time towards the three-day in-patient hospital stay needed for Medicare to cover your skilled nursing facility stay.

5. Hospice Care

If Individual is Not Eligible For Medicare

The Retiree Health Plan pays the Charges for a hospice care program, subject to limits as set forth in the applicable Schedule of Benefits. To obtain hospice care coverage under the plan, the doctor must certify to the third party administrator that you are terminally ill. Terminally ill means you have or your Covered Eligible Dependent has been diagnosed as having six months or fewer to live, due to a terminal illness.

Charges are paid only for services ordered by the physician supervising the program. Care provided at a hospice facility includes pain control and other acute and chronic symptom management.

The following charges for hospice care services are not included as covered expenses:

- c. for the services of a person who is a member of your family or your Covered Eligible Dependent 's family or who normally resides in your home, or your Dependent's home;
- d. custodial care services;

- e. for any period when you or your Covered Eligible Dependent is not under the care of a physician;
- f. for any curative or life-prolonging procedures;
- g. to the extent that any other benefits are payable for those expenses under the plan; or
- h. for services or supplies that are primarily to aid you or your Covered Eligible Dependent in daily living.

If Individual is Eligible For Medicare

The Medicare Supplemental Plan covers only those expenses for hospice services that are covered under Medicare and assumes Medicare is primary.

6. In-patient Rehabilitative Care

If Individual is Not Eligible For Medicare

The Retiree Health Plan pays for in-patient rehabilitative care, subject to limits as set forth in the applicable Schedule of Benefits. The Retiree Health Plan pays for semi-private room and for other covered services and supplies.

Rehabilitative care is care needed to restore you to 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.

Rehabilitative care is covered only when such care follows a treatment plan approved by the third party administrator. This plan must specify the type of treatment, give the frequency and duration of the treatment and provide an ongoing review. Coverage for rehabilitative care may be continued beyond the duration of the treatment plan when therapy is necessary, as determined by third party administrator.

If Individual is Eligible For Medicare

The Medicare Supplemental Plan covers only those expenses that are covered under Medicare and assumes Medicare is primary.

7. Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. The following limitation applies to short-term rehabilitative therapy. Short-term rehabilitative therapy is provided only when medically necessary and restorative in nature for purposes of enabling individuals to perform the activities of daily living. Payment for these services is subject to the applicable schedule of benefits.

Services that **are not covered** include but are not limited to:

- i. sensory integration therapy, group therapy;
- ii. treatment of dyslexia;
- iii. behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- iv. treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
- v. maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.

8. In-patient Mental Health and Substance Abuse Services

If Individual is Not Eligible For Medicare

The Retiree Health Plan provides for in-patient mental health services which include partial hospitalization and mental health residential treatment services subject to the following rules and the applicable Schedule of Benefits.

- a. Partial hospitalization sessions are periods of inpatient treatment during which services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.
- b. Mental health residential treatment services are services provided by a hospital or other health care facility for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute mental health conditions.
- c. A mental health residential treatment center is an institution which: (a) specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
- d. A person is considered confined in a mental health residential treatment center when she/he is a registered bed patient in a mental health residential treatment center upon the recommendation of a physician.
- e. Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, Charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be Charges made for treatment of substance abuse.

The following are specifically excluded from mental health and substance abuse services:

- a. Any court-ordered treatment or therapy; or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations, unless medically necessary and otherwise covered under this plan.
- b. Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- c. Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- d. Counseling for activities of an educational nature.
- e. Counseling for borderline intellectual functioning.
- f. Counseling for occupational problems.
- g. Counseling related to consciousness raising.
- h. Vocational or religious counseling.
- i. I.Q. testing.
- j. Custodial care, including but not limited to geriatric day care.
- k. Psychological testing on children requested by or for a school system.
- l. Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

If Individual is Eligible For Medicare

The Medicare Supplemental Plan covers only those expenses that are covered under Medicare and assumes Medicare is primary.

9. Home Health Care

Home health care refers only to care provided instead of hospitalization or confinement in a skilled nursing facility. The care must be provided by a licensed and approved home health care agency. The Retiree Health Plan pays Charges for up to 200 home health care days in a calendar year.

To qualify for home health care coverage under the Retiree Health Plan, your doctor must submit, and have approved by, a written home health care plan to the third party administrator. The plan must certify that you (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a hospital or other health care facility.

The Retiree Health Plan pays for charges made by an approved home health care agency for services and supplies ordered by your doctor and provided at home including:

- a. Part-time or intermittent nursing provided or supervised by a registered nurse. This generally consists of visits by an R.N. or licensed practical nurse to perform specific nursing skills such as cleaning and dressing open or infected wounds and administering intravenous solutions.
- b. Part-time or intermittent services provided by a home health aide, primarily for the care of a recovering patient.
- c. Physical, occupational, speech or respiratory therapy by a qualified therapist.
- d. Nutrition advice provided or supervised by a registered dietician.
- e. Medical supplies, drugs and laboratory services.

If you are a minor or an adult who is dependent upon others for non-skilled care and/or custodial care services (e.g., bathing, eating, toileting), home health services will be provided for you only during times when there is a family member or care giver present in the home to meet your non-skilled care and/or custodial care service needs.

The home health care Retiree Health Program does not include the following:

- a. transportation services;
- b. custodial care (non-skilled care that involves assisting a person in the usual activities of daily living and is not provided under a home health care plan as described above);
- c. services provided by someone who lives with you or is a member of your family or your spouse/domestic partner's family;
- d. any services or supplies that are not part of the home health care plan.

If Individual is Eligible For Medicare

The Medicare Supplemental Plan covers only those expenses that are covered under Medicare and assumes Medicare is primary.

10. Transplant Services

If Individual is Not Eligible For Medicare

The Retiree Health Plan pays for Charges made for human organ and tissue transplant Services which include solid organ and bone marrow/stem cell

procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant Services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement.

Transplant Services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

Transplant Services are covered at 100% when received in-network. Benefits for Transplant Services, including corneal, received at participating facilities that are specifically contracted with the third party administrator for those transplant services, are payable at the In-network benefit level.

Benefits for transplant services received at any other facilities, including non-participating providers and participating providers not specifically contracted with the third party administrator for transplant services, are payable at the out-of-network benefit level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if medically necessary.

Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

If Individual is Eligible For Medicare

The Medicare Supplemental Plan covers only those expenses that are covered under Medicare and assumes Medicare is primary.

G. PART VII -- Medical Benefits – In General

Medical benefits are covered for necessary care, and include doctor visits, services, supplies, outpatient care for treatment of alcohol and substance abuse and coverage for second surgical opinions. Although the Retiree Health Plan does not generally cover routine preventive health checkups, coverage is included for cytology screenings, and mammography screenings.

Beginning January 1, 2013, if you use an in-network provider, there is an annual medical deductible. If you use an out-of-network provider, after you pay your annual medical deductible, the plan generally pays a percentage of the Charges for most services. You pay the remaining percentage.

1. Out-of-Pocket Maximum

After you reach your out-of-pocket maximum, the Retiree Health Plan pays 100% of the in-network Charges and 100% of the out-of-network Charges you incur during the calendar year. Some charges are not counted toward your out-of-pocket maximum. Charges that are not counted toward your out-of-pocket maximum include:

- a. charges you incur in excess of in-network or out-of-network Charges;
- b. payments for services and supplies not covered under the plan, including any services and supplies that are not medically necessary;
- c. charges you incur in excess of any other plan limits;
- d. your monthly contributions for this plan; or
- e. hospital or other inpatient deductibles, co-payments or penalties for failure to pre-certify.

2. The following is a list of some, but not all, services that are not covered:

- Services and supplies that are not medically necessary, as determined by the third party administrator, for the diagnosis, care or treatment of the physical or mental condition involved, even if prescribed, recommended or approved by the attending physician.
- Services and supplies that any school system is required to provide under law.

- Services and supplies that are not prescribed, recommended and approved by the individual's attending physician.
- The portion of any Charges for services and supplies that the third party administrator determines is in excess of Charges.
- Charges for services and supplies that are made only because coverage exists.
- Charges for services and supplies that a covered individual is not legally obligated to pay.
- Services and supplies furnished by or for the U.S. Government or any other government unless payment is legally required.
- Services and supplies to the extent they are paid by any public retiree health program, government retiree health program or law – other than Medicaid – under which you are, or could be, covered.
- Services and supplies paid by no-fault insurance.
- Services and supplies furnished to treat 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.
- Prescription drugs and medications, except those dispensed during a hospital stay or approved under a home health care or hospice plan, which are not considered experimental or investigational.
- Custodial care, whether provided at home or in a nursing home or other institution.
- Routine check-ups or annual physical examinations, immunizations, and any other services or supplies that are not necessary for medical care of a diagnosed injury or illness, except as described or specified otherwise.
- Physician's services or X-rays involving one or more teeth, the tissue or structure around them, the alveolar process or the gums.
- Exclusion applies even if the condition being treated involves a part of the body other than the mouth such as treatment of temporomandibular joint disorders or malocclusion involving joints or muscles. However, 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 six months of the accident.
- Vision training and eye surgery to correct nearsightedness, farsightedness or astigmatism.
- Acupuncture, unless a doctor provides it and it is necessary as determined by the third party administrator.

- Cosmetic surgery or therapy, including surgery to treat a mental, psychoneurotic or personality disorder. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Reconstructive surgery is covered if it is incidental to or follows other surgery required as a result of injury, infection or disease, or if it is performed to correct a bodily function impaired by a birth disease or defect.
- Personal comfort items.
- Nursing, speech therapy, physical therapy, occupational therapy or home health care provided by you, your spouse or a child, brother, sister or parent of you or your spouse.
- Charges for or in connection with speech therapy; provided, however, that the 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 an injury, stroke or congenital anomaly.
- Charges for education, special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Charges for or in connection with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial.
- Charges for procedures, services, drugs and other supplies that are, as determined by the third party administrator, experimental or still under clinical investigation by health professionals. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review physician to be:

- i. not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
 - ii. not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - iii. the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
 - iv. the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- Charges for the reversal of a sterilization procedure.
 - Charges for therapy, supplies, or counseling for sexual dysfunctions or inadequacies.
 - Charges for or related to sex change surgery or any treatment of gender identity disorders.
 - Charges for any services or supplies if the provision of such benefit is prohibited by any law of the jurisdiction in which the individual resides at the time the service or supply is received.
 - Any services or supplies provided to treat injuries or sickness caused by an act of war that occurs while you are covered by the Retiree Health Plan.
 - Charges made by a hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected injury or sickness.
 - Charges for or in connection with an injury or sickness which is due to war, declared or undeclared.
 - Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial care services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
 - Regardless of clinical indication for macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupuncture; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
 - For or in connection with treatment of the teeth or periodontium, unless such expenses are incurred for: (i) Charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth;

- (ii) charges made by a hospital for bed and board or necessary services and supplies; (iii) charges made by a free-standing surgical facility or the outpatient department of a hospital in connection with surgery.
- For medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
 - Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
 - court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this plan.
 - transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
 - any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
 - medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under this plan.
 - Non-medical counseling or ancillary services, including, but not limited to: custodial care services, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety; and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
 - therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
 - consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips.
 - artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.

- aids or devices that assist with non-verbal communications, including, but not limited to: communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Charges made for eye exercises; and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all prescription drugs, non-prescription drugs, and investigational and experimental drugs.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree (or as a Dependent thereof), when payment is denied by Medicare because treatment was received from a non-participating provider.
- medical treatment, when payment is denied by a Primary Plan because treatment was received from a non-participating provider.
- for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for Charges which would not have been made if the person had no insurance.
- for Charges incurred out-of-network, to the extent that they exceed Charges.

- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care (emergency care) while temporarily traveling abroad.
- Charges made by any covered provider who is a member of your family or your dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

3. Hearing Care and Additional Exclusions

The Retiree Health Plan covers limited hearing exams, aids, and care which is explained in the Schedule of Benefits. Additional exclusions, include but are not limited to:

- any hearing care services or supplies that do not meet professionally accepted standards;
- any hearing aid that is experimental in nature as determined by the third party administrator;
- any ear exam that is required by an employer as a condition of employment;
- any ear exam that is required by any law of any government; and
- lenses and frames or hearing aids furnished or ordered because of an exam that was done before the date the individual becomes eligible for coverage.

H. PART IX -- Prescription Drug Plan

If you are a CECONY Retiree, **not** covered under an HMO, and are covered by the Retiree Health Plan, you may elect the Prescription Drug Plan administered by CVS Caremark Inc. If you are an O&R Retiree, and you are covered under the Retiree Health Plan, you will be automatically covered.

If you are eligible for Medicare, effective January 1, 2013, the Retiree Health Plan provides benefits for necessary prescription drugs through a prescription card and a mail order program that is a Group Medicare Part D Plan.

If you are a CECONY Retiree, coverage under the Prescription Drug Plan is separate from Retiree Health Plan. You can elect to enroll in Retiree Health Plan only or you can elect to enroll in the Prescription Drug Plan only, or you can enroll in both plans. There is a separate deductible, co-payments and premium for coverage.

If you have family coverage and would like to change to individual coverage, please contact HR Service Center or O&R Benefits Department. Also refer to the Schedule of Benefits for information regarding a deductible, co-payments and other costs, if any, for coverage.

Prescription Drug Plan

Depending upon the nature of the prescription and whether you use the mail order, you may be eligible to obtain up to a 90-day supply of necessary medications under the Prescription Drug Plan. After you meet the annual individual deductible, if applicable, you pay a specific co-payment for each prescription. The amount of your co-payment depends on whether you are a CECONY Retiree, an O&R Management Retiree, or an O&R Local 503 Retiree and whether your prescription is filled with a generic or name-brand drug – generic drugs cost less than name-brand drugs. Current plan deductibles and co-payments are shown in the applicable Schedule of Benefits.

Covered Drugs

The Prescription Drug Plan covers most FDA approved legend drugs and medicines that require a prescription from a doctor. Compounded medication must include at least one prescription legend drug. Only FDA approved drugs are covered.

Maintenance Drugs for Chronic Conditions – Insulin and drugs prescribed for chronic conditions are covered under the Prescription Drug Plan. Under the Prescription Drug Plan, prescription drugs for chronic conditions may be dispensed in amounts up to a 90 day supply. It may be more economical to obtain these drugs through the mail order or at a CVS pharmacy.

Refills – The Prescription Drug Plan covers prescription refills. Authorized refills may be filled only up to one year from the date of the original prescription. After one year, you must obtain a new prescription from your doctor.

Caremark Participating Pharmacies

Many pharmacies participate in the CVS Caremark network. Upon election, CVS Caremark issues a CVS Caremark identification card for you and Your Covered Eligible Dependent when you retire.

Filling a Prescription at Non-Participating Pharmacies

If you have a prescription filled at a non-participating pharmacy, pay the full cost of the prescription and complete a CVS Caremark prescription drug claim form and mail it to the address on the claim form.

Claim forms are available from CVS Caremark Inc. You can call CVS Caremark at 1-800-601-6364 or write to CVS Caremark Inc., Box 659541, San Antonio, TX 78265-9541.

You are reimbursed based on the discounted cost of the prescription to the plan at a participating pharmacy, less your applicable co-payment. There may be a significant difference between the price you pay at a non-participating pharmacy and the discounted cost. The difference you pay is solely your responsibility.

Mail-Order Prescriptions

If you take name-brand or generic prescription medications on a continuing basis for a chronic condition, you may be eligible to receive up to a 90-day supply through the mail-order Prescription Drug Plan. Every prescription medication is not available on a mail order basis.

Covered Drugs

The mail-order Prescription Drug Plan 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.

How to Obtain Mail Service Benefits

1. Ask your doctor whether the prescription he or she is prescribing may be written for up to a 90-day supply. If so, request him or her to prescribe maintenance medication for up to a 90-day supply.
2. To obtain a maintenance drug you are already taking, first use up whatever remaining amount on your current prescription and then ask your doctor for a new prescription for a 90-day supply. The law requires that pharmacies (including CVS Caremark) dispense the exact quantity prescribed by a doctor. Your doctor must prescribe a 90-day supply for you to receive that quantity.
3. Complete the Caremark mail service order form. Be sure to answer all the questions, and mail to the address listed on the order form.
4. Use the return envelope to mail in your completed Caremark mail service order form and your prescription(s). Please do not enclose your CVS Caremark prescription card.
5. CVS Caremark processes your order and sends your medications by first-class U.S. mail or insured UPS, along with reorder instructions for future prescriptions and/or refills. You should allow up to 21 days for delivery.

If You Need Medication Immediately and a CVS pharmacy is not accessible

If you need medication immediately and a CVS pharmacy is not accessible and you will be taking it on a long-term basis, ask your doctor for two prescriptions – the first for a 21-day supply that you can have filled at a local pharmacy with your prescription card and the second for up to a 90-day supply. Send the second prescription to CVS Caremark immediately with your completed mail service order form.

Prescription Drug Exclusions

The following drugs, supplies and services are not covered under the Prescription Drug Plan. It is very important to keep in mind that as prescription care continues to change, it is not always possible to determine whether a prescription drug or supply will be covered. If a

prescription drug or supply is not specifically listed, it still may not be covered. If you have any questions, you should call CVS Caremark before you incur any expense.

Some of the prescription drugs or supplies not covered include:

- Non-legend drugs;
- Experimental drugs or drugs labeled “Caution – limited by federal law to investigational use;”
- Cosmetic drugs;
- Over-the-counter medications (except insulin);
- 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);
- Immunization agents, biological sera, blood or blood plasma;
- Charges for the administration or injection of any drug;
- 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;
- Any other pharmaceutical items not classified as legend drugs;
- Minoxidil (Rogaine) for the treatment of alopecia; or
- Prescriptions which an eligible person is entitled to receive without charge under any workers compensation law, or any municipal, state or federal program.

Some items not covered under the Prescription Drug Plan may be covered under the hospital/medical benefits provided by the Retiree Health Plan. These include Charges for administering or injecting drugs, and Charges for medication taken or administered in a hospital.

If you are entitled to Medicare, beginning January 1, 2013, the Prescription Drug Plan is a Group Medicare Part D Plan administered by an affiliate company of CVS Caremark referred to as SilverScript. CECONY and O&R have an agreement with SilverScript under which SilverScript will provide a Group Medicare Part D Plan customized for our Retirees and Participants.

If Individual is Eligible For Medicare

1. If a CECONY Retiree or his or her Covered Eligible Dependent is eligible for Medicare, he or she may elect to participate in the Prescription Drug Plan. If he or she elects the Medicare Part D, there will be no coverage under the Prescription Drug Plan for that year. There is no coordination of benefits between the Prescription Drug Plan and Medicare Part D.
2. Each individual who is eligible for Medicare may elect during each open enrollment 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. If you are eligible for Medicare and you do not elect coverage under the Prescription Drug Plan, Medicare Part D or any other group coverage, you will not be eligible in the future to re-enroll in the Prescription Drug Plan.

I. PART X -- How to Make a Claim for Benefits – The Claims Procedure

In general, in most instances, if you or your Covered Eligible Dependent has a claim for a service, supply, expense, or benefit that is not or will not be covered in part or in full under the Retiree Health Program, you must assert your claim to the applicable Claims Fiduciary. There is a Claims Fiduciary for the Retiree Health Plan, for the Prescription Drug Plan, and for the HMOs. You must ensure that you notify the proper Claims Fiduciary.

The Claims Fiduciary is the legal entity who will provide you with your claims procedure. In most cases, you must exhaust these claims procedures before you will be entitled to bring legal action. There are special claims procedures under a health plan governed by ERISA, such as the Retiree Health Program depending upon whether the claim is classified as an urgent care claim, a pre-service claim, a post-service claim or a concurrent care claim. If your claim is about eligibility, termination of coverage, or a matter other than a specific health care related claim, you are required to follow the regular claims procedure.

Requests for advance information on possible coverage of or approval for items or services do not constitute pre-service claims. The Claims Fiduciary is responsible for determining whether a claim is an urgent care claim, a pre-service claim, a post-service claim or a concurrent care claim. The Claims Fiduciary determines the

nature of the claim, whether the claim has been properly filed, and the number of days the Claims Fiduciary has to respond to the claim. The Claims Fiduciary has been delegated the full discretion and authority to make all decisions with regard to these claims and the determinations by the Claims Fiduciary are final, binding, and conclusive.

1. Special Claims Procedures

- a. An **urgent care claim** is a claim for health care that is needed quickly to avoid seriously jeopardizing the life or health of you or your. An urgent care claim is also a claim where the health care provider determines that you or your dependent is in severe pain. The initial determination as to whether an urgent care claim will be paid will be made within 72 hours of receipt of the properly filed claim. You or your Covered Eligible Dependent (the "Claimant") must file a proper claim; failure to do so will delay the determination by the Claims Fiduciary. If an urgent care claim is filed improperly, within 24 hours after the urgent care claim is received, the Claims Fiduciary will notify the Claimant of the improper filing and how to correct it. If additional information is needed to process the claim, within 24 hours after the claim is received, the Claims Fiduciary will notify the Claimant of the information needed. The Claimant has no less than 48 hours to provide the requested information. The Claimant will be notified of a determination no later than 48 hours after (a) the receipt by the Claim Fiduciary of the requested information; or (b) the end of the period within which the Claimant was to provide the additional information, if the information is not received within that time. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.
- b. A **pre-service claim** is a claim in which prior approval is needed before the claim will be covered and paid for in whole or in part. A pre-service claim includes a request for preauthorization to obtain receiving a larger benefit (e.g., payment of 75% rather than 50%) of the expense. If the claim is a pre-service claim, the initial decision regarding the claim will be made within 15 days of receipt of the properly filed claim. If the Claimant files a pre-service claim improperly, within 5 days after the pre-service claim is received, the Claims Fiduciary will notify the Claimant, in writing or orally, of the improper filing and how to correct it. If additional information is needed to process the

pre-service claim, within 15 days after the claim is received, the Claims Fiduciary will notify the Claimant of the information needed. The Claims Fiduciary may request a one-time extension of up to 15 days. The claim is “tolled” until all information is received. Once notified of the need for more information, the Claimant has 45 days to provide the information. If all of the needed information is received within the 45-day time frame, the Claims Fiduciary will notify the Claimant of the determination within 15 days after the information is received. If the Claimant does not provide the needed information within the 45-day period, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

- c. A **post-service claim** is a claim for payment of medical care that has already been rendered. If the claim is a post-service claim, the initial decision regarding a post-service claim will be made within 30 days of the properly filed claim. If additional information is needed, within the 30-day period, the Claims Fiduciary will notify the Claimant. The Claims Fiduciary also may request a one-time extension of up to 15 days to process the post-service claim. If the extension of time is necessary due to the failure of the Claimant to submit necessary information, the Claimant has at least 45 days to provide the requested information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Fiduciary will notify the Claimant of the denial within 15 days after the information is received. If the Claimant does not provide the needed information within the 45-day period, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan Option on which the denial is based, and provide the claim appeal procedures.

- d. A **concurrent care claim** is a claim for ongoing treatment, covering either a period of time or a number of treatments, for which the Claims 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 you or your Covered Eligible Dependent receiving the ongoing care. The Claims Fiduciary will provide notice of the reduction or termination of the coverage sufficiently in advance to allow for an appeal and decision on appeal. If it is a claim seeking to extend ongoing urgent health care, a plan must notify the Claimant whether the claim has been approved or denied within 24 hours after receiving it.

- e. Extensions are available for pre-service and post-service claims when there are circumstances that are beyond the control of the Claims Fiduciary; e.g., the Claims Fiduciary can extend the time if more information is needed from the Claimant. Time is “tolled” from the point that the Claims Fiduciary notifies the Claimant about the need for the additional information until the Claimant responds with the information.

2. Appeals Under the Special Claims Procedures

- a. If the Claimant is filing an appeal of an urgent care claim, the Claims Fiduciary will make a determination and notify the Claimant of that determination within the 72-hour period following the receipt of the Claimant’s request for an appeal of an adverse benefit determination.
- b. If the Claimant is filing an appeal of a pre-service claim, the Claims Fiduciary may provide for one or two internal appeals of an adverse benefit determination. If the Claims Fiduciary provides for one internal appeal of an initial adverse benefit determination, the Claims fiduciary will make a determination and notify the Claimant of that determination within the 30-day period following the receipt of the Claimant’s request for an appeal of an adverse benefit determination. If the Claims Fiduciary provides for two internal appeals of an initial adverse benefit determination, the first appeal will be made and the Claims Fiduciary will notify the Claimant of the first determination within the 15-day period following the receipt of the Claimant’s request for an appeal. The second level of appeal will be made and the Claims Fiduciary will notify the Claimant of the second determination within 15 days from receipt of the Claimant’s request for a review of the first level appeal decision.
- c. If the Claimant is filing an appeal of a post-service claim, the Claims Fiduciary may provide one or two internal appeals of an adverse benefit determination. If the Claims Fiduciary provides for one level of internal appeal of an initial adverse benefit determination, the Claims fiduciary will make a determination and notify the Claimant of that determination within the 60-day period following the receipt of the Claimant’s request for an appeal of an adverse benefit determination. If the Claims Fiduciary provides for two internal appeals of an initial adverse benefit determination, the first appeal will be made and the Claims Fiduciary will notify the Claimant of the first

determination within the 30-day period following the receipt of the Claimant's request for an appeal. The second level of appeal will be made and the Claims Fiduciary will notify the Claimant of the determination within 30 days from receipt of the Claimant's request for a review of the first level appeal decision.

- d. In both pre- service and post-service claims that provide for two internal appeals, the Claimant must make a request for the second level of appeal within 60 days following receipt of the first level appeal decision.

3. Requirements for Appeals under the Special Claims Procedure

- a. The appeal of an adverse determination of a health care claim will be made by a Medical Expert Fiduciary who is not a subordinate of the initial decision maker. The Medical Expert Fiduciary will accept new evidence or information and the review will be de novo. The Claims Fiduciary will consult with an appropriate Medical Expert Fiduciary in deciding appealed claims involving medical judgment.
- b. A Claimant has 180 days to file an appeal of a denied claim under the Claims and Special Claims Procedures.

4. Regular Claims

- a. A Claimant whose initial application for a Regular Claim is denied, in whole or in part, may appeal from an adverse determination to the Plan Administrator, or if applicable, the Claims Fiduciary, for a review of the decision. The Plan Administrator or Claims Fiduciary will establish reasonable procedures for determining whether an individual is an authorized representative of the Claimant. The Plan Administrator and each Claims Fiduciary has been delegated legal authority to exercise full and absolute discretion and to make final and conclusive determinations and decisions.
- b. The Plan Administrator or Claims Fiduciary will notify the Claimant of the adverse determination within 90 days after receipt of the initial claim. If the Plan Administrator or Claimant determines that an extension of time is needed to process the claim, within the first 90-day period, the Claims Fiduciary or Plan Administrator will notify, in writing, the Claimant of a need

for an extension. The extension of time to make the determination may not exceed an additional 90-day period.

- c. If the Plan Administrator or Claims Fiduciary makes an adverse benefit determination, the notice of the adverse decision will provide the specific reason(s) for the adverse determination, the specific plan provision(s) on which the decision is based, a description of additional information necessary to perfect the claim, and a description of the review and appeal procedures, including time limits for bringing appeals.
- d. If the Claimant wants to appeal the initial determination, he or she must submit to the Plan Administrator or the Claims Fiduciary, within sixty days after receiving written notice of the denial of the claim, a written request for an appeal. The statement must request an appeal setting forth all of the grounds upon which the request for review is based, any facts in support thereof, and any issues or comments which the Claimant deems relevant to the appeal.
- e. The Plan Administrator or the Claims Fiduciary must act within sixty days after the later of receipt of the Claimant's request for an appeal or receipt of any additional materials reasonably requested by the Plan Administrator or the Claims Fiduciary from such Claimant. If the Plan Administrator or Claims Fiduciary determines that an extension of time is needed to process the appeal, within the first 60-day period, the Claims Fiduciary or Plan Administrator will notify, in writing, the claimant of a need for an extension. The extension of time to make the determination of the appeal may not exceed an additional 60-day period.
- f. The Plan Administrator or the Claims Fiduciary will make a full and fair review of each appeal. The Plan Administrator or Claims Fiduciary may require the Claimant to submit, within sixty days after receiving a written notice, additional facts, documents or other evidence as is deemed necessary or advisable, in the sole discretion of the Plan Administrator or the Claims Fiduciary, in making such a review.
- g. On the basis of the review, the Plan Administrator or the Claims Fiduciary will make an independent determination of the Claimant's claim for benefits under the Plan Option. The decision regarding the appeal of the Claimant by

the Plan Administrator or the Claims Fiduciary on any application for benefits shall be final, binding, and conclusive upon all persons.

- h. If the Plan Administrator or the Claims Fiduciary denies an application appeal, in whole or in part, the Plan Administrator or the Claims Fiduciary will give written notice of the decision to the Claimant setting forth the specific reasons for such denial and specific references to the pertinent Plan Option provisions on which the decision is based.

5. Notice and Proof of Claim

- a. The third party administrator must be given to written notice within 30 days after the date on which the claim is based. If written notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.
- b. Proof of Claim or Loss – Written proof of the claim must be given to the third party administrator within 90 days after the date for which the claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible

J. PART XI - Coordination of Benefits with Other Plans, Subrogation, Reimbursement, and Overpayments

The Retiree Health Program applies a coordination of benefits provision (COB) that is triggered if you or Your Covered Eligible Dependent(s) are covered by any other group health plan, an Exchange based plan, a government plan other than Medicare or Medicaid, a “no-fault” motor vehicle coverage, or any other plan that pays or would pay for you or Your Covered Eligible Dependent health, medical, or prescription drug expenses, supplies, or services.

The Retiree Health Program additionally asserts its full subrogation, reimbursement, and overpayment rights in the event medical, vision, hospitalization, or prescription drug expenses paid by the Retiree Health Program are also paid by another entity for whatever reason, are paid when not legally required to be paid, or are paid as a result of fraudulent behavior.

1. Coordination of Benefits

1. Special Definitions for the Coordination of Benefits Provisions:

- a. **Allowable Expense** means a necessary service or expense, including deductibles, coinsurance or a copayment, that is covered in full or in part by any Plan covering You or Your Covered Eligible Dependent. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit. Expenses or services that are **not Allowable Expenses** include, but are not limited to the following:

- i. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
 - ii. If You are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
 - iii. If You are covered by two or more Plans that provide services or supplies on the basis of, any amount in excess of the highest Maximum Reimbursable Charge or the Pre-negotiated Charge is not an Allowable Expense.
 - iv. If You are covered by one Plan that provides services or supplies on the basis of Maximum Reimbursable Charge and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
 - v. If Your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because You did not comply with "Plan Provisions," as defined in this paragraph, or because You did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Plan Provisions mean and include second surgical opinions and precertification of admissions or services.
- b. **Claim Determination Period** means a calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.
 - c. **Closed Panel Plan** means a Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.
 - d. **Our Plan** means the Retiree Health Program.
 - e. **Plan** means the following Plans with which Our Plan coordinates benefits and includes, but is not limited to (and includes all and any plans that

provides for medical care or treatment), other group health Plans, government plans, (other than Medicaid), States' "no-fault" motor vehicle coverage and any of the following that provides benefits or services for medical care or treatment:

- i. Group insurance, insurance through an Exchange, and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
 - ii. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
 - iii. Medical benefits coverage of group, group-type, and individual automobile contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.
- f. **Primary Plan** means the Plan that determines and provides or pays benefits without taking into consideration the existence of any Other Plan.
- g. **Secondary Plan** means the Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you or to your dependent
- h. **Reasonable Cash Value** means an amount which a duly licensed provider of health care services usually Charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.
- i. **That or Those Plans** means all other Plans.
2. In accordance with the COB provisions, Our Plan, taking into account Those Plans and the terms of Our Plan, in the aggregate, may reimburse You or Your Covered Eligible Dependent for up to a total of but not more than 100% of the Charges for Allowable Expenses, as determined by the applicable Plan. Depending upon which

Plan pays first, Our Plan may reduce the amount of benefits it provides to You. In the event an Other Plan has a COB provision which is inconsistent with Our Plan, Our Plan coordination provision will be deemed operative. You should file all claims with each Plan.

3. When You are or Your Covered Eligible Dependent is covered by Our Plan and That Plan, the following rules apply. If That Plan does not have a coordination of benefits provision similar to this provision, That Plan pays first, regardless of these rules.

a. Non-Dependent or Dependent Rule

- i. The Plan covering You as an employee pays before the Plan covering you or your Covered Eligible Dependent as a dependent pays.
- ii. For example, if Our Plan covers your spouse as your dependent but your spouse is actively working and his or her employer's Plan ("That Plan") covers him or her as an active employee, then your spouse's medical expenses are paid for first from That Plan.
- iii. There is a special exception to the "non-dependent or dependent rule." If the Plan covering you or your Covered Eligible Dependent as a dependent is primary to Medicare and the Plan covering you or Covered Eligible Dependent as a retiree is secondary to Medicare, then the order of benefits is reversed so that the Plan covering you or your Covered Eligible Dependent as a nondependent is covering you or your Covered Eligible Dependent as a dependent. For example, if Our Plan is primary to Medicare for you and That Plan is secondary to Medicare for you, Our Plan pays first without regard to the "non-dependent rule."

b. Covered Eligible Dependent Child Who Is Covered Under Two Plans

If a dependent child is covered under both parents' Plans, and the parents are not divorced or legally separated, the New York State birthday rule applies:

- i. Birthday Rule - If the Covered Eligible Dependent is a Dependent Child covered under more than one Plan then the birthday rule applies. The birthday rule provides: (1) The Plan of the parent whose birthday falls

earlier in the year (regardless of the year of birth) pays first. (2) If the parents have the same birthday, even if they were born in different years, the Plan that has covered one of them for the longer period of time pays first. (3) If one parent's Plan follows the birthday rule and the other doesn't, the father's Plan pays first.

- ii. Court Decree Determines - If the parents are separated or divorced, benefits are paid first-by 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. The specifics of the Court Decree Rules are set forth in detail in the Retiree Health Program.
- iii. 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 set forth in detail in the Retiree Health Program Plan.

c. Active or Inactive Rule

- i. If a Plan covers You or Your Covered Eligible Dependent as a retiree, dependent child, or spouse, that Plan pays after another Plan covering You or Your Covered Eligible Dependent as an active employee or dependent of an active employee.
- ii. 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.

d. Continuation Coverage Rule

The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If The Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

e. That Plan Does Not Have a COB

If That 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. If none of the rules above determines which Plan pays first, the Primary Plan is the Plan that has covered you or Your Covered Eligible Dependent for a longer period of time.

f. Order of Payment

- i. When you are covered under a Plan as an active employee (or as that employee's Dependent), That Plan is the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) is the Secondary Plan.
- ii. If the other Plan does not have a coordinating provision similar to the Retiree Health Plan's, the other Plan pays first, regardless of these rules.
- iii. If That Plan covers you as a laid-off or retired employee or the dependent of a laid-off or retired employee, That Plan pays after another Plan covering you as an active employee or the 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, and as a result, each Plan determines its benefits after the other.)
- iv. If none of the rules above determines which Plan pays first, the Primary Plan is the Plan that has covered you for a longer period of time.
- v. If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

4. When Coordinating Benefits with Medicare

When coordinating benefits with Medicare, Our Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. When more than one Plan is secondary to Medicare, the

benefit determination rules identified above will be used to determine how benefits will be coordinated.

5. Effect on the Benefits of Our Plan

If Our Plan is the Secondary Plan, Our Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that Our Plan would have paid if Our Plan had been the Primary Plan, and the benefit payments that Our Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. The third party administrator will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

6. Recovery of Excess Benefits

If Our Plan is the Secondary Plan and the third party administrator pays for benefits that should have been paid by the Primary Plan, or if the third party administrator pays in excess of those for which we are obligated to provide under the Our Plan, the third party administrator will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

The third party administrator will have sole and absolute discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

7. Right to Receive and Release Information

The third party administrator, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of

Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

8. If Individual is Medicare Eligible

The third party administrator will pay as the Secondary Plan as permitted by the Social Security Act of 1965, as amended for the following:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan; (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan; (c) a retired Employee (or a Dependent thereof) who is eligible for Medicare due to End Stage Renal Disease, after that person has been eligible for Medicare for 30 months;

The third party administrator will assume the amount payable under:

- a. Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he or she would receive if he or she had applied.
- b. Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he or she would receive if he or she were enrolled.
- c. Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he or she would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him or her.

2. Refund of Overpayments

If the Retiree Health Program pays expenses and all or some of those expenses were either not paid or legally did not have to be paid by you or your Covered Eligible Dependent, or exceeded the allowable benefits under the Retiree Health Program ("Overpayment") you or your Covered Eligible Dependent, or any other person or organization that was paid, must refund the Overpayment to the Retiree Health Program.

The amount of the Overpayment equals the amount paid in excess of the amount that should have paid under the Retiree Health Program. If the Overpayment is due from a third party, you or your Covered Eligible Dependent will agree to assist in obtaining the Overpayment when requested. If you not or your Covered Eligible Dependent do not promptly repay the full amount of the Overpayment, the Retiree Health Program will reduce the amount of any future benefits that are payable under the Retiree Health Program. The reductions will equal the amount of the required Overpayment.

3. Expenses For Which A Third Party May Be Responsible

The Retiree Health Program does not cover expenses incurred by you or your Covered Eligible Dependent for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness. The Retiree Health Program does not cover expenses incurred by you or your Covered Eligible Dependent to the extent any payment is received for you or your Covered Eligible Dependent either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

4. Subrogation and Right of Reimbursement

The Retiree Health Program or Employer will be subrogated and succeed to you or your Covered Eligible Dependent (or, in the event of your death or incapacity, your lawful beneficiary or estate) under any theory of right of recovery against a third party. The Retiree Health Program 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 Retiree Health Program for the same medical services and benefits. As a condition of participation in the Retiree Health Program, you and your Covered Eligible Dependent consent and agree that the Retiree Health Program, in its sole discretion, may exercise this right when requested.

The Retiree Health Program is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right

of reimbursement is cumulative with and not exclusive of the subrogation rights granted in the Retiree Health Program, but only to the extent of the benefits provided by the plan. Whenever the term subrogation is used, included is the right of reimbursement and overpayment.

In the event of any payment under the Retiree Health Program, through its Plan Administrator, or Named Fiduciary, the Retiree Health Program shall be subrogated to all the rights of recovery of yours or your Covered Eligible Dependent. You or your Covered Eligible Dependent 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 Retiree Health Program to bring suit in your name or the name of your Covered Eligible Dependent. If you or your Covered Eligible Dependent has a claim against another person or third party for payment of the medical or other Charges, the Retiree Health Program will be subrogated to all rights you or your Covered Eligible Dependent may have against that other person or third party and will be entitled to reimbursement.

You or your Covered Eligible Dependent must:

- a. assign or subrogate to the Retiree Health Program your or your Covered Eligible Dependent's rights to recovery when this provision applies;
- b. acknowledge that the Retiree Health Program's rights will be considered as the first priority claim against third parties, to be paid before any other of claims are paid without regard to whether you or your Covered Eligible Dependent is or is not made whole by the recovery;
- c. authorize the Retiree Health Program to sue, compromise and settle in your name or the name of your Covered Eligible Dependent to the extent of the amount of medical or other benefits paid and expenses incurred by the Retiree Health Program;
- d. reimburse the Retiree Health 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 Retiree Health Program;
- e. notify the Retiree Health Program in writing of any proposed settlement and

obtain the Retiree Health Program's written consent before signing any release or agreeing to any settlement;

- f. do nothing to prejudice the rights of the Retiree Health Program under this provision, either before or after the need for services or benefits under any Plan Option;
- g. whether or not you or your Covered Eligible Dependent has been fully compensated, allow the Retiree Health Program to collect from the proceeds of any full or partial recovery that you or your Covered Eligible Dependent or your or your Covered Eligible Dependent's legal representative 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;
- h. hold in trust for the benefit of the Retiree Health Program under these subrogation provisions any proceeds of settlement or judgment;
- i. authorize the Retiree Health Program to recover reasonable attorney fees incurred in collecting proceeds held by you or your Covered Eligible Dependent; and
- j. 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.

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 Retiree Health Program in collecting this amount. The right of reimbursement also applies when you or your Covered Eligible Dependent recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan. The Retiree Health Program will not offset the reimbursement for your or your Covered Eligible Dependent's legal costs attributable to recovery from a third party. The Retiree Health Program has the right to full subrogation and reimbursement of any and all amounts paid by the Retiree Health Program, to or on behalf of, you or your Covered Eligible Dependent. If you or your Covered Eligible Dependent receives any sum of money from any third party in connection with any accident,

you or your Covered Eligible Dependent will be responsible for all expenses of recovery from such third parties, including but not limited to, all attorneys' fees, which fees and expenses shall not reduce the amount of reimbursement to the Retiree Health Program. You or your Covered Eligible Dependent will reimburse:

- a. 100% of the amount of covered benefits paid;
- b. any payments so made by the Retiree Health Program out of any monies recovered from third parties;
- c. the amount of benefits the Retiree Health Program has paid;
- d. any payments resulting from a judgment or settlement; or
- e. other payment or payments, made or to be made by any person or persons considered responsible for the condition giving rise to the medical expense or by their insurers;

5. Lien of the Plan

By accepting benefits under the Retiree Health Program, You or your Covered Eligible Dependent: (1) grants a lien and assigns to the Retiree Health Program an amount equal to the benefits paid under the Retiree Health Program against any recovery made by or on behalf of You or your Covered Eligible Dependent which is binding on any attorney or other party who represents the You or your Covered Eligible Dependent whether or not an agent of the You or your Covered Eligible Dependent or of any insurance company or other financially responsible party against whom a You or your Covered Eligible Dependent may have a claim provided said attorney, insurance carrier or other party has been notified by the Retiree Health Program or its agents; (2) agrees that this lien shall constitute a charge against the proceeds of any recovery and the Retiree Health Program shall be entitled to assert a security interest thereon; and (3) agrees to hold the proceeds of any recovery in trust for the benefit of the Retiree Health Program to the extent of any payment made by the Retiree Health Program.

6. Additional Terms

- a. Neither you nor an adult Covered Eligible Dependent hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of you or an adult Covered Eligible Dependent without the prior express written consent of the Retiree Health Program. The Retiree Health Program's right to recover shall apply to

- decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- b. You or your Covered Eligible Dependent shall not make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Retiree Health Program.
 - c. The plan's right of recovery shall be a prior lien against any proceeds recovered by the You or your Covered Eligible Dependent. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
 - d. You or your Covered Eligible Dependent hereunder shall not incur any expenses on behalf of the Retiree Health Program in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the Retiree Health Program. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
 - e. The Retiree Health Program shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of you or your Covered Eligible Dependent, whether under comparative negligence or otherwise.
 - f. In the event that you or your Covered Eligible Dependent shall fail or refuse to honor its obligations hereunder, then the Retiree Health Program shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Retiree Health Program shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until you or your Covered Eligible Dependent has fully complied with his or her reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
 - g. Any reference to state law in any other provision of this Retiree Health Program shall not be applicable to this provision. By acceptance of benefits, you or your Covered Eligible Dependent agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Retiree Health Program shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Retiree Health Program, including, but not limited to, specific performance,

restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

7. Payment of Benefits

To Whom Payable

All medical benefits are payable to you. However, at the option of the third party administrator, all or any part of them may be paid directly to the person or institution on whose charge claim is based. Medical benefits are not assignable unless agreed to by the third party administrator.

The third party administrator may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Covered Eligible Dependent from a non-participating provider, even if benefits have been assigned. When benefits are paid to you or your Covered Eligible Dependent, you or your Covered Eligible Dependent is responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of the third party administrator, is not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. If no request for payment has been made by his or her legal guardian, the third party administrator may, at its option, make payment to the person or institution appearing to have assumed his custody and support. If you die while any of these benefits remain unpaid, the third party administrator may choose to make direct payment to any of your following living relatives: spouse; mother or father; child or children; brothers or sisters; or to the executors or administrators of your estate. Payment as described above will release the third party administrator from all liability to the extent of any payment made.

K. PART XII - THE HMO OPTION

The HMO Option offers health care benefits through health maintenance organizations (HMOs). This option is an alternative to the Retiree Health Plan. A list of HMOs included in the HMO Option and their toll-free telephone numbers is shown on the supplemental page in the back pocket of this booklet.

For Retirees who are not eligible for Medicare, the HMO Option generally provides health care benefits similar to those currently available under the Retiree Health Plan.

For Retirees who are eligible for Medicare, the HMO Option provides health care benefits instead of Medicare. This means that the HMO Option provides coverage for all doctor visits, hospital care, prescription drugs, tests and other services generally covered through Medicare.

An HMO is a group of doctors, hospitals, health care centers, laboratories, pharmacies and other health care providers who work together to provide health care services to patients. There are two basic types of HMOs- a staff model HMO that provides services at a medical center affiliated with the HMO and an individual practitioner association (IPA) model HMO that is a group of doctors in private practice who provide services to HMO members.

HMOs that provide service through IPAs and those that combine medical centers and individual practitioner associations are listed on the supplemental page in the back pocket of this booklet.

If you enroll in an HMO, you must use the HMO doctors and facilities for all your health care. To help you do this, you choose a personal doctor – called a primary care physician or PCP– from among the HMO’s group of doctors. A primary care physician is generally an internist or family practitioner who has been retained by the HMO and has passed the HMO’s and Medicare’s credentialing criteria. The primary care physician you select studies your medical history and monitors your health, so he or she can coordinate the care you receive. Your primary care physician oversees your checkups, tests and preventive care, and monitors any medications you may be taking. When necessary, your primary care physician arranges referrals to specialists or hospital admissions.

All HMOs offered through the HMO Option include out-of-area coverage for emergency care. If you have a medical emergency while you’re traveling and can’t see your primary care physician or go to an HMO hospital, you’re still covered under your HMO. Out-of-area coverage for each HMO is defined in the written material provided by the HMO.

HMOs manage care differently than the Retiree Health Plan.

L. PART XIII - When Coverage Ends

1. If you die before your spouse, and your spouse is not an eligible surviving spouse, coverage under the Retiree Health Program ends for your spouse and each dependent child. If you and your surviving spouse both die, coverage terminates for any surviving dependent children. Coverage also ends:
 - a. when you or your surviving spouse voluntarily cancels coverage in writing;
 - b. when you or of your Covered Eligible Dependent children becomes covered as an employee under another group health plan;
 - c. when you or Your Covered Eligible Dependent engages in fraud against the Retiree Health Program;
 - d. when your spouse or one of your dependent children ceases to belong to a group eligible for the Retiree Health Program – for example, when one of your children no longer meets the definition of a dependent child, or if your spouse becomes divorced from you;
 - e. if you or your surviving spouse stops paying your required monthly contribution;
 - f. the date the Retiree or a Covered Eligible Dependent engages in fraud, misrepresentation, or providing false information in which case each Retiree and Covered Eligible Dependent loses coverage;
 - g. the date the Retiree engages in conduct which, if performed as an active employee, would have caused the Retiree to be ineligible for COBRA in which case each Retiree and Covered Eligible Dependent lose coverage;
 - h. if the Retiree Health Program is terminated or is replaced by other coverage;
or
 - i. if coverage for spouses, surviving spouses or dependent children is terminated under the Retiree Health Program.

2. COBRA

In limited circumstances, your spouse and your dependents may be able to elect continuation coverage. This coverage is available under the provisions of a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), if coverage under this Retiree Health Program would otherwise end.

Under COBRA, your spouse may be eligible to continue medical coverage for up to 36 months if coverage would otherwise end because of your death or a divorce or legal separation. Your dependent children may be eligible to elect continuing coverage under COBRA for up to 36 months if they lose coverage because of your death, your divorce or legal separation, or the end of their eligibility as a “dependent child” under the plan.

These events must be reported to the Plan Administrator within 60 days. Your spouse or dependent children can elect COBRA coverage for the Retiree Health Plan or the HMO Option by paying the full cost of coverage plus a two percent administrative fee. They must elect coverage within 60 days from the receipt of a notice from the Plan Administrator about COBRA coverage. They have an additional 45 days to pay back any premiums.

COBRA coverage can continue for up to 36 months – depending on the reason for continuation. However, coverage ends before the 36-month limit if your spouse or dependent children fail to pay the required premiums; your spouse or dependent children become covered under another group health plan or eligible for Medicare; or Con Edison no longer offers medical coverage to its Retirees.

3. Rescission or cancellation

If you or Your Covered Eligible Dependent intentionally misrepresents information to the Retiree Health Program or to the Company, or knowingly misinforms, deceives, or misleads the Retiree Health Program, or knowingly withholds relevant information, and unless there are extenuating extraordinary factors, coverage will be cancelled retroactively to the date deemed appropriate by and in the full discretion of the Plan Administrator. Further, you or Your Covered Eligible Dependent will be required to reimburse the Plan for Claims paid by the Retiree Health Program.

The Retiree Health Program may choose to pursue civil and/or criminal action. You or Your Covered Eligible Dependent will no longer be eligible for coverage because of such actions. In addition if you or Your Covered Eligible 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 you and

Your Covered Eligible Dependents are disqualified from eligibility for coverage under the Program.

M. Part XIV - Plan Information – Retiree Health Program

Notice of Privacy Standards Under HIPAA

The Retiree Health Retiree will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“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”).

Payment means activities undertaken by the Retiree Health Program to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to you or your Covered Eligible Dependent to whom health care is provided.

These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost-sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing Participant contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of Charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review;

- 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); and
- reimbursement to the Retiree Health Retiree Health Program.

Operations mean, but are not limited to, the following health care related activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- 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);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Retiree Health Program, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Master Health Plan, including, but not limited to:
 - management activities relating to implementation of and compliance with HIPAA's administrative simplification requirements, or customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
 - resolution of internal grievances; and
 - due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

With an authorization, the Retiree Health Program will disclose PHI to the Employers, the Consolidated Edison Retirement Plan, the Consolidated Edison Master Health Plan, the Long-Term Disability Plan for Weekly Employees of Consolidated Edison Company of New York, Inc., the for the purposes related to TPO activities of these plans.

The Retiree Health Program will disclose PHI to CECONY, as 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.

- The Plan Sponsor and each Employer agrees to:
- not use or further disclose PHI other than as permitted or required by the Retiree Health Program document or as required by law;
- 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 with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- 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;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Retiree Health Program available to the HHS Secretary for the purposes of determining the Retiree Health Program's compliance with HIPAA; and
- 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).
- 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.

N. PART XV - The following information is provided in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA).

1. Funding

The Retiree Health Program is currently funded through contributions by Participants in the Retiree Health Program and by Con Edison and O&R. These contributions are made to a trust fund under the company's pension plan, exclusively for CECONY, and to trust funds established by Con Edison and O&R. The Retiree Health Program and its trust are employee welfare benefit plans under ERISA and the trust funds are intended to qualify as a voluntary employees' beneficiary association (VEBA), exempt from federal income taxes under Section 501(c) (9) of the Internal Revenue Code of 1986, as amended.

2. Name and Address of Employer and Plan Sponsor

Plan Sponsor and Employer for CECONY Retirees - Consolidated Edison Company of New York, Inc.; 4 Irving Place; New York, NY 10003

Plan Sponsor and Employer for O&R Retirees - Orange & Rockland Utilities, Inc.; One Blue Hill Plaza; Pearl River, NY 10965-9006

3. Plan Identification

The plan that makes up the Retiree Health Program is identified by the following number:

The Consolidated Edison Retiree Health Program:
Con Edison's Employer Identification Number – 13-5009340
O&R Management Retirees Group Insurance Plan – 514
O&R Hourly Retirees Group Insurance Plan - 515

4. Type of Plan

The Retiree Health Program provides hospitalization, medical, prescription drug, and vision care welfare benefits to eligible Retirees, eligible spouses and their eligible dependents.

5. Type of Administration

The Retiree Health Plan is the hospital, medical and vision care benefits that are self-insured and administered by a third party administrator. The Prescription Drug Plan is self-insured and administered by a third party administrator. The HMO Options are administered by each individual HMO.

6. Plan Administrator

Vice President – Human Resources
Consolidated Edison Company of New York, Inc.
4 Irving Place
New York, NY 10003
(212) 460-4600

7. Trust Fund Trustee

State Street Bank and Trust Company
Master Trust Services
PO Box 1992
Boston, MA 02105-1992

Con Edison has the right to appoint and remove the Trustee.
Administrative expenses of the Retiree Health Program and the Trust Funds are paid by the Trust Funds.

8. Agent for Service of Legal Process

For disputes arising under the Retiree Health Program, service of legal process may be made on the Plan Administrator.

9. Plan Year

The fiscal records of the plans are kept on the basis of a plan year, which is the 12-month period beginning each January 1st and ending December 31st.

10. Fiduciary Functions

If you have any questions about your eligibility for coverage under Retiree Health Program or about the provisions of the Retiree Health Program, you may write to the Plan Administrator.

In carrying out their respective responsibilities under the Retiree Health Program, the Plan Administrator and other fiduciaries have discretionary authority to control and manage the operation and administration of the Retiree Health Program. The Plan Administrator has authority to interpret the terms of the Retiree Health Program and to determine eligibility for and entitlement to benefits under the Retiree Health Program, to determine any facts and resolve any questions relevant to administration of the Retiree Health Program and to remedy and correct any ambiguities, inconsistencies or omissions in the Retiree Health Program.

Any action taken by the Plan Administrator or other fiduciaries pursuant to such discretionary authority shall be conclusive and binding on all Participants, beneficiaries and others.

The Plan Administrator has authority to determine whether to provide benefits through insurance or otherwise; to select the companies to insure and/or administer benefits; to change the level of benefits to be provided and the level of Participant contributions, deductibles and co-payments; to select the HMOs that participate in the HMO Option and to make changes in the Retiree Health Program, including the HMO Option, in order to facilitate administration of the Retiree Health Program.

11. Future of the Retiree Health Program

The Employers currently sponsor the Retiree Health Program, but reserve the right to change or end the Retiree Health Program at any time. In addition, the Employers reserve the right to determine from time to time the level of contributions required from plan Retirees and all participants for coverage.

If the Employers decide to change or end the Retiree Health Program, their decision may be due to changes in laws governing employee benefit plans, the requirements of the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA), or any other reason.

12. Statement of ERISA Rights

As a plan Participant, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

- Examine, without charge, at the Employee Benefits Department, 4 Irving Place, 15th Floor South, New York, NY 10003, all plan documents, insurance contracts, and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file

suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Retiree Health Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

If you have more questions about the Retiree Health Plan or your HMO that are not answered in this booklet, you can call for the HR Service Center at 1-800-582-5056 for CECONY, or O&R Benefits at 1-800-577-9527 for O&R.

13. Special Provision Affecting Only Local 503 Retirees

If you are a retiree of O&R and were a member of Local 503 when you were actively employed, changes, modifications, and terminations are subject to the applicable collective bargaining agreement.

Schedule of Benefits

For Individuals Who Not Eligible For Medicare Applies to CECONY Retirees, O&R Management Retirees, and O&R Local 503 Retirees and Their Covered Eligible Dependents

SUMMARY

The Retiree Health Plan, sometimes called the OAP, provides coverage for care In-Network and Out-of-Network. To receive benefits, You or Your Covered Eligible Dependents may be required to pay a portion of the Covered Expenses which is called a copayment, a deductible or coinsurance.

1. **Coinsurance** means the percentage of Charges for Covered Expenses that You or Your Covered Dependent is required to pay.
2. **Copayments/Deductibles** are expenses to be paid by You or Your Covered Dependent for Covered Services. Deductible amounts are separate from and are not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. You or Your Covered Eligible Dependent may have an inpatient admission/hospital deductible called a hospital deductible and a medical deductible.
3. **Out-of-Pocket Expenses** are Covered Expenses incurred for charges that are not paid by the Plan.
4. **Out-of-Pocket Maximum** means that when the Out-of-Pocket Maximum is reached, Covered Expenses are payable by the Retiree Health Plan at 100%. However, some expenses that do not contribute to the Out-of-Pocket Maximum such as non-compliance penalties, any copayments and/or benefit deductibles, and excess provider Charges.

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Lifetime Maximum: Hospital and Medical Combined Lifetime Maximum Limit	For a CECONY Retiree - There is a one million dollar lifetime limit which, when exhausted, and whether before or after age 65, does not get refreshed. For an O&R Retiree – There is a one million dollar limit that ends upon attainment of age 65. At age 65, when covered under the Medicare Supplemental Plan, the lifetime limit changes to thirty-five thousand dollars.					
The Percentage (%) of Covered Expenses the Retiree Health Plan Pays						

Throughout the **Schedule of Benefits**, the Retiree Health Plan pay “Charges” as defined here:

1. **“Charges”** for an in-network provider or a participating provider means the pre-negotiated discount fee or pre-negotiated contract rate, as determined solely by the third-party administrator.
2. **“Charges”** for an out-of-network provider or a non-participating provider means the Maximum Reimbursable Charge, as determined solely by the third-party administrator, and as defined above.
3. **“Charges”** under the Medicare Supplemental Plan means the Medicare Allowable Amount also known as Medicare Reimbursable Amount, as determined by Medicare.

The Maximum Reimbursable Charge is determined based on the lesser of

1. the provider’s normal charge for a similar service or supply; or
2. a percentile of charges made by providers of such service or supply in the geographic area where the service is received.
3. These charges are compiled in a database the third party administrator has selected.

The Maximum Reimbursable Charge is based on the determination of the third party administrator and is final, binding, within the absolute discretion of the third party administrator, and applicable to all parties.

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Physician's Services						
Primary Care Physician (PCP) Office Visit	100% after PCP copay	100% after PCP copay	100% after PCP copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
Specialty Care Physician's Office Visits	100% after Specialist copay	100% after Specialist copay	100% after Specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
Surgery Performed in the Physician's Office	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Second Opinion Consultations (provided on a voluntary basis)	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Allergy Treatment/Injections	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Preventive Care / Immunizations –						
Routine Preventive Care for children through end of the month in which the child attains age 23	100%	100%	100%	100%	100%	100%
Immunizations for age 0 through 23- based on U.S. guidelines	100%	100%	100%	100%	100%	100%
Shingles vaccine	100%	100%	100%	100%	100%	100%
Well Woman Annual Exam	100%	100%	100%		100%	100%
Mammograms – based on age & American Medical Association guidelines	100%	100%	100%	100%	100%	100%
Diagnostic Mammograms, PSA, Pap Smear	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible

CECONY Retirees and O&R Mgmt Retirees: The inpatient hospital – facility admissions is subject each year to a deductible that is 50% of the Medicare hospital deductible for that year. The Medicare deductible is applied even if You are not eligible for Medicare. This deductible applies to both in-network and out-of-network admission.

O&R Local 503 Retirees: As of Plan Year 2013, \$150 hospital deductible, \$450 out of network medical deductible subject to changes based on CBA.

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Inpatient Hospital - Facility Services	100% of the limits, below, after hospital deductible	100% of the limits below, after hospital deductible	100% of the limits below, after hospital deductible	70% of the limits below, after hospital deductible	80% of the limits below, after hospital deductible	80% of the limit below, after hospital deductible
Semi-Private Room and Board	Limited to the semi-private room of the negotiated rate	Limited to the semi-private room of the negotiated rate	Limited to the semi-private room of the negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Private Room Of the Charges-	Limited to the semi-private room of the negotiated rate	Limited to the semi-private room of the negotiated rate	Limited to the semi-private room of the negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the negotiated rate	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Charges for Facility	100%	100%	100%	100%	80% after medical deductible	80% after medical deductible
Inpatient Hospital Physician's Visits	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Inpatient Hospital Professional Services:						
Surgeon	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Outpatient Professional Services - Surgeon	100%	100%	100%	100%	80% after medical deductible	80% after medical deductible
Radiologist, Pathologist, Anesthesiologist	100%	100%	100%	100%	80% after medical deductible	80% after medical deductible
Emergency and Urgent Care Services						
Hospital Emergency Room *waived if admitted	100% after ER copay*	100% after ER copay*	100% after ER copay*	100% after ER copay*	100% after ER copay* if true emergency; if not, 80% after medical deductible	100% after ER copay* if true emergency; if not, 80% after medical deductible
Radiology, Pathology and ER Physician in the Hospital Emergency Room	100%	100%	100%	100% if true emergency; if not, 70% after medical deductible	100% if true emergency; if not, 80% after medical deductible	100% if true emergency; if not, 80% after medical deductible
Urgent Care Facility	100% after Specialist copay	100% after the greater of the PCP or Specialist copay	100% after the greater of the PCP or Specialist copay	100% after Specialist copay*	100% after the greater of the PCP or Specialist copay	100% after the greater of the PCP or Specialist copay

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Ambulance	90% after medical deductible	100%	100%	90% after medical deductible – except if not true emergency, then 70% after medical deductible	100% if true emergency; if not true emergency, 80% after medical deductible	100% if true emergency; if not true emergency, 80% after medical deductible
Inpatient Services at Other Health Care Facilities Includes skilled nursing facility, rehabilitation hospital, and sub-acute facilities and precertification required	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Laboratory and Radiology Services (includes pre-admission testing) at other health care facilities						
1. Physician office	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
2. Outpatient Hospital Facility	100%	100%	100%	100%	80% after medical deductible	100% after medical deductible
3. Independent X-ray and/or Lab Facility	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)						
Physician's Office	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Inpatient Facility-precertification required	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Outpatient Facility	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Outpatient Short-Term Rehabilitative Therapy						
Physical Therapy, Speech Therapy and Occupational Therapy	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Calendar Year Maximum:						
CECONY Retirees – 30 day limit per therapy						
O&R Management & Local 503 – 60 day limit per therapy						
Pulmonary Rehabilitation Therapy - outpatient	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Cognitive Therapy-outpatient	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Cardiac Rehabilitation- outpatient O&R Management & Local 503 – 90 day maximum per calendar year	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Home Health Care Calendar Year Maximum: 200 days (includes outpatient private nursing when approved as medically necessary)	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Hospice						
Inpatient Services	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Outpatient Services	100%	100%	100%	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Bereavement Counseling Services provided as part of Hospice Care						
Inpatient	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Outpatient	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Maternity Care Services						
Initial Visit to Confirm Pregnancy	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
Delivery - Facility (Inpatient Hospital, Birthing Center) – precertification required	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Abortion						
Inpatient Facility	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Inpatient Professional Services	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Outpatient Facility	100%	100%	100%	100%	80% after medical deductible	80% after medical deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Physician's Services	100%	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
Family Planning Services						
Office Visits, Lab and Radiology Tests and Counseling	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)						
Physician's Office Visit	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	100% after the PCP or Specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
Inpatient Facility O&R - precertification required	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Outpatient Facility O&R - precertification required	100%	100%	100%	100%	80% after medical deductible	80% after medical deductible
Physician's Services	100%	100%	100%	70% after Medical deductible	80% after Medical deductible	80% after Medical deductible

Infertility Treatment

Coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Physician's Office Visit (Lab and Radiology Tests, Counseling)	100% after PCP or Specialist copay	No coverage	No coverage	70% after medical deductible	No coverage	No coverage
Inpatient Facility Pre-certification required	100% after hospital deductible	No coverage	No coverage	70% after hospital deductible	No coverage	No coverage
Outpatient Facility	100%	No coverage	No coverage	100%	No coverage	No coverage
Physician's Services	100%	No coverage	No coverage	70% after medical deductible	No coverage	No coverage
Organ Transplants all medically appropriate, non- experimental transplants						
Physician's Services	100% at Lifesource center, otherwise 100%			70% after medical deductible	80% after medical deductible	80% after medical deductible
Inpatient Facility (pre-certification required)	100% at Lifesource center, otherwise 100% after hospital deductible			70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Lifetime Travel Maximum: \$10,000 per transplant	Lifesource facility			NOT COVERED		

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Durable Medical Equipment pre-certification required if over a certain amount	90% after medical deductible	100%	100%	70% after medical deductible	80% after medical deductible	80% after medical deductible
External Prosthetic Appliances Orthotics covered with a diagnosis of diabetes only	90% after medical deductible	100%	100% orthotics: \$300 per calendar year maximum for diagnosis of diabetes only	70% after medical deductible	80% after medical deductible	80% after medical deductible orthotics: \$300 per calendar year maximum for diagnosis of diabetes only
Hearing Exams	100% after PCP or specialist copay	100% after PCP or specialist copay	100% after PCP or specialist copay	70% after medical deductible	80% after medical deductible	80% after medical deductible
Hearing Aids CECONY Lifetime Maximum: \$600 O&R Calendar year maximum \$2,800 & 1 set of hear aids	100% after medical deductible	100%	100% after medical deductible	Same as in-network	100%	100%
Surgical and Non-Surgical TMJ						

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Non-Surgical TMJ Physician's Office Visit-up to \$500 maximum per calendar year	100% after PCP or specialist copay	100% after PCP or specialist copay	100% after PCP or specialist copay	70% after medical plan deductible	80% after medical plan deductible	80% after medical plan deductible
Surgical TMJ	100% after PCP or specialist	100% after PCP or specialist	not covered	70% after medical plan	80% after medical plan	80% after medical plan
Weight Reduction (Bariatric Surgery)						
Inpatient Facility pre-certification required	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Outpatient Facility	100%	100%	100%	100%	80% after medical deductible	80% after medical deductible
Physician Services	100% after PCP or Specialist copay	100% after PCP or Specialist copay	100% after PCP or Specialist copay	70% after medical plan deductible	80% after medical plan deductible	80% after medical plan deductible
Outpatient Services	100%	100%	100%	100%	80% after medical plan deductible	80% after medical plan deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Dental Care limited to Charges made for continuous course of dental treatment started within specified time of the accidental injury						
Dr.'s Office	100% after PCP or Specialist copay	100% after PCP or Specialist copay	100% after PCP or Specialist copay	70% after medical plan deductible	80% after medical plan deductible	80% after medical plan deductible
Inpatient Facility pre-certification required	100% after hospital deductible	100% after hospital deductible	100% after hospital deductible	70% after hospital deductible	80% after hospital deductible	80% after hospital deductible
Outpatient Facility	100%	100%	100%	100%	80% after medical plan deductible	80% after medical plan deductible

	IN-NETWORK			OUT-OF-NETWORK		
	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees	CECONY Retirees	O&R Mgmt Retirees	O&R Local 503 Retirees
Wigs covered due to hair loss from Chemotherapy one wig per lifetime	90% after medical plan deductible	100%	100%	70% after medical plan deductible	80% after medical plan deductible	80% after medical plan deductible

**For Individuals Who Are Eligible For Medicare
 Medicare Supplemental Plan
 Schedule of Benefits
 Applies to
 CECONY Retirees, O&R Management Retirees, and
 O&R Local 503 Retirees and
 Their Covered Eligible Dependents**

	Medicare	Retiree Health Plan (Plan)
<i>Lifetime Maximum</i> <i>Applies to all expenses; Part A and Part B expenses cross accumulate to the lifetime maximum and, for CECONY, applies and takes into account all expenses paid until Medicare eligible</i>	Not Applicable	CECONY - \$1,000,000 taking into account and including in the \$1,000,000 all costs paid while in the Retiree Health Plan before age 65/covered under Medicare. O&R - \$35,000 beginning at age 65
<i>Coinsurance Levels</i>		
Part A Expenses	Generally 100% after Medicare hospital deductible or copayment – based on Medicare rules	CECONY - 100% of the amount approved but not paid by Medicare and after Plan hospital deductible O&R - 80% of the amount approved but not paid by Medicare
Part B Expenses – First Medicare Part B Deductible	Medicare Part B deductible must first be paid by CECONY Retiree and O&R Retiree	

	Medicare	Retiree Health Plan (Plan)
Remainder of Part B Expenses	Generally 80% or subject to Medicare rules	CECONY - 70% of the amount approved but not paid by Medicare and after medical deductible is met O&R - 80% of the amount approved but not paid by Medicare and after medical deductible is met
<i>Calendar Year Deductible</i> <i>Applies to Part B expenses For the Retiree Health Plan</i>		
Individual		CECONY - \$650 that includes Medicare Part B deductible O&R - \$135
Family		CECONY - \$1,950 (includes Medicare Part B deductible) O&R - no family deductible – each person has individual deductible
<i>Out-of-Pocket Maximum</i> Applies to Part B expenses only and includes mental health and substance abuse Part B expenses	Medicare does not have an out of pocket maximum	
Includes Plan Deductible		CECONY: Yes, O&R: N/A
Includes Plan Coinsurance		CECONY: Yes, O&R: N/A
Individual Maximum		CECONY: \$3,200, O&R: N/A

	Medicare	Retiree Health Plan (Plan)
Part A Expenses		
■		
Hospital Calendar Year Deductible <i>Applies to Part A expenses</i>		
Individual	Medicare rules	CECONY – 50% of the Medicare Part A deductible O&R – no deductible
Inpatient Hospital - Facility Services <i>Semi-private room and board, general nursing and miscellaneous services and supplies. A new benefit period begins each time the member is out of the hospital more than 60 days.</i>		
First 60 days per benefit period:	After Medicare A deductible, Medicare pays subject to Medicare rules	CECONY - 100% of the amount approved but not paid by Medicare and after Plan hospital deductible O&R – 80% of the amount approved but not paid by Medicare

	Medicare	Retiree Health Plan (Plan)
61 st -90 th day per benefit period:	After Medicare A deductible, Medicare pays subject to Medicare rules	CECONY - 100% of the amount approved but not paid by Medicare and after Plan hospital deductible O&R – 80% of the amount approved but not paid by Medicare
91 st day and after per benefit period: while using 60 lifetime reserve days	After Medicare A deductible, Medicare pays subject to Medicare rules	CECONY - 100% of the amount approved but not paid by Medicare and after Plan hospital deductible O&R – 80% of the amount approved but not paid by Medicare
<i>Inpatient Hospital - Facility Services – Buy Up</i> <i>Once Lifetime Reserve days are used (or would have ended if used) additional 365 days per benefit period per person per lifetime</i>		
Days 1-365	\$0	100% after Plan hospital deductible

	Medicare	Retiree Health Plan (Plan)
<p><i>Inpatient Services at Other Health Care Facilities</i></p> <p><i>Includes Skilled Nursing facility; Rehabilitation Hospital; and sub-acute Facilities</i></p> <p><i>Medicare requires that a beneficiary must have been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.</i></p>		
<p>First 20 days per benefit period:</p>	<p>Medicare pays subject to Medicare rules</p>	<p>CECONY – N/A as Medicare pays 100% for the 1st 20 days O&R – N/A as Medicare pays 100% for the 1st 20 days</p>
<p>21st thru 100th day per benefit period:</p>	<p>Medicare pays subject to Medicare rules</p>	<p>CECONY - 100% of the amount approved but not paid by Medicare after Plan hospital deductible</p> <p>O&R – 80% of the amount approved but not paid by Medicare</p>

	Medicare	Retiree Health Plan (Plan)
<p><i>Inpatient Services at Other Health Care Facilities – 101st thru 365th day:</i></p>	<p>Medicare pays subject to Medicare rules</p>	<p>CECONY - 100% of the amount approved but not paid by Medicare after Plan hospital deductible</p> <p>O&R – 80% of the amount approved but not paid by Medicare</p>
<p><i>Hospice/Inpatient Respite Care</i> <i>Medicare requires that the patient is terminally ill to be eligible for hospice benefits</i></p>	<p>Medicare pays subject to Medicare Rules</p>	<p>CECONY – 100% of the amount approved but not paid by Medicare after Plan hospital deductible</p> <p>O&R – 80% of the amount approved but not paid by Medicare</p>

	Medicare	Retiree Health Plan (Plan)
<i>Part B Expenses</i>		
■		
<i>Outpatient Physician Services For</i>		
Primary Care Physician Office Visit	Generally, Medicare pays 80% subject to Medicare rules for each of the five outpatient physician services	CECONY – 70% of the amount approved but not paid by Medicare after Plan medical deductible
Specialty Care Physician Office Visit		O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible
Second Opinion Consultations		
Allergy treatment/injections		
Surgery Performed in Physician's office		CECONY - 100% of the amount approved but not paid by Medicare
		O&R - 80% of the amount approved but not paid by Medicare after Plan medical deductible

	Medicare	Retiree Health Plan (Plan)
<p><i>Preventive Care Standard</i></p> <p><i>Medicare covered services</i></p>	Medicare pays subject to Medicare rules	<p>CECONY – 100% of the amount approved but not paid by Medicare after Plan medical deductible</p> <p>O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible</p>
<p><i>Preventive Care – Buy Up</i></p> <p><i>Non Medicare covered preventive services</i></p> <p><i>Medicare covered preventive services including one annual Wellness visit</i></p> <p>Well Woman Exam – One per year</p> <p>Shingles Vaccine</p>	<p>\$0</p> <p>100%</p> <p>80%</p> <p>\$0</p>	<p>1. CECONY - Not covered O&R - Not covered</p> <p>2. CECONY - Not covered O&R - Not covered</p> <p>3. CECONY – 100% of the amount approved but not paid by Medicare</p> <p>O&R - 80% of the amount approved but not paid by Medicare</p> <p>CECONY – 100% O&R – no coverage</p>

	Medicare	Retiree Health Plan (Plan)
<p><i>Outpatient Facility Services</i> Operating room, Recovery Room, Procedures Room and Treatment Room</p>	80% subject to Medicare rules	CECONY – 100% of the amount approved but not paid by Medicare O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible
<p><i>Inpatient Hospital Doctor's Visits/Consultations</i></p>	80% subject to Medicare Rules	CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible
<p><i>Inpatient Hospital Professional Services</i> Surgeon Assistant Surgeon Radiologist Pathologist Anesthesiologist</p>	80% subject to Medicare Rules	CECONY – 70% of the amount approved but not paid by Medicare after Plan medical deductible O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible

	Medicare	Retiree Health Plan (Plan)
<p><i>Outpatient Professional Services</i></p> <p>Surgeon Radiologist Pathologist Anesthesiologist</p>	80% subject to Medicare Rules	<p>CECONY – 100% of the amount approved but not paid by Medicare after Plan medical deductible</p> <p>O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible</p>
<p><i>Emergency and Urgent Care Services</i></p>	80% subject to Medicare Rules	<p>CECONY – 100% of the amount approved but not paid by Medicare after a \$100 Emergency Room per visit copay</p> <p>O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible</p>
<p><i>Ambulance</i></p>	80% subject to Medicare Rules	<p>CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible</p> <p>O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible</p>

	Medicare	Retiree Health Plan (Plan)
<i>Laboratory and Radiology Services</i> <i>(includes Pre Advanced Imaging)</i>	80% subject to Medicare Rules	CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible
<i>Pre Admission testing</i>	80% subject to Medicare Rules	CECONY 100% of the amount approved but not paid by Medicare O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible

	Medicare	Retiree Health Plan (Plan)
<i>Outpatient Short Term Rehabilitation and Chiropractic Care</i>	80% subject to Medicare Rules	<p>CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible. Physical, occupational, and speech therapy is each limited to 30 visits per calendar year. Chiropractic care is subject to certain limits.</p> <p>O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible. Chiropractic care is limited to one \$50.00 amount per calendar year.</p> <p>Physical, occupational, and speech therapy is limited to 60 visits, in the aggregate, per calendar year.</p>
<i>Acupuncture</i>	\$0	<p>CECONY - 70% after Plan medical deductible of the Charge</p> <p>O&R – no coverage</p>

	Medicare	Retiree Health Plan (Plan)
<p><i>Home Health Care</i></p> <p>Maximum: 200 days per calendar year</p>	<p>100% if covered under Part A</p> <p>80% if covered under Part B</p>	<p>CECONY - 100% of the amount approved but not paid by Medicare after plan medical deductible</p> <p>O&R - 80% of the amount approved but not paid by Medicare after plan medical deductible</p>
<p><i>Durable Medical Equipment</i></p>	<p>80% subject to Medicare Rules</p>	<p>CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible</p> <p>O&R - 80% of the amount approved but not paid by Medicare after Plan medical deductible</p>
<p><i>External Prosthetic Appliances including Orthotics for diagnosis of Diabetes</i></p>	<p>80% subject to Medicare Rules</p>	<p>CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible</p> <p>O&R - 80% of the amount approved but not paid by Medicare after Plan medical deductible</p>

	Medicare	Retiree Health Plan (Plan)
<i>Diabetic Supplies and Services</i>	80% subject to Medicare Rules	CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible O&R - 80% of the amount approved but not paid by Medicare after Plan medical deductible
<i>Wigs for hair loss due to Chemotherapy</i> O&R: limit of 1 wig per lifetime	\$0	CECONY -70% after plan deductible O&R – 80% of the amount approved but not paid by Medicare after Plan medical deductible
<i>Part B Covered Prescription Drugs</i>	Generally 80%	CECONY - 70% of the amount approved but not paid by Medicare after Plan medical deductible O&R - 80% of the amount approved but not paid by Medicare after Plan medical deductible

	Medicare	Retiree Health Plan (Plan)
<i>Mental Health and Substance Abuse</i>		
Inpatient	Same as hospital inpatient	Same as hospital benefits
Partial Hospitalization	Same as Outpatient Hospital	Same as Outpatient Hospital
Outpatient	Same as medical benefits	Same as medical benefits
<i>Foreign Travel</i> <i>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</i>		Covered as any other illness

Benefit Exclusions *(by way of example but not limited to):*

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

Additional coverage limitations determined by plan or provider type are shown in the Schedule.

Payment for the following is specifically excluded from this plan:

- 1) Any expense that is:
 - a) Not a Medicare Eligible Expense; or
 - b) beyond the limits imposed by Medicare for such expense; or
 - c) excluded by name or specific description by Medicare; except as specifically provided under the "Covered Expenses" section
- 2) Any portion of a Covered Expense to the extent paid or payable by Medicare;
- 3) Any benefits payable under one benefit of this plan to the extent payable under another benefit of this plan;
- 4) Covered Expenses Incurred after coverage terminates;
- 5) Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

CECONY RETIREES CVS CAREMARK PRESCRIPTION DRUG PLAN				
		Non-Medicare Eligible		Medicare Eligible
Annual Prescription Deductible		\$100 per person		\$100 per person
Retail Co-payment		\$15 generic \$30 name-brand		\$15 generic \$30 name-brand
Mail Order Co-payment		\$15 generic \$30 name-brand		\$15 generic \$30 name-brand

ORANGE & ROCKLAND UTILITIES RETIREES CVS CAREMARK PRESCRIPTION DRUG PLAN				
		Non-Medicare Eligible		Medicare Eligible
Annual Prescription Deductible		\$75 per person		\$75 per person
Retail Co-payment		\$10 generic \$20 name-brand		\$10 generic \$20 name-brand
Mail Order Co-payment		\$7 generic \$14 name-brand		\$7 generic \$14 name-brand