Summary of Employee Benefits

Agreement Employees

Check the “Weekly News””, the Metro-North and BSC Websites for notices about benefit plan changes, option transfer and re-enrollment periods.

333 W 34th Street
NEW YORK, NY 10001

Telephone: 646-376-0123
Fax: 212-852-8700

Email: bscservice@mtabsc.org

Effective 1/1/2013
This is a summary of the following company sponsored benefits.

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The official plan description and official company policy takes precedence over this summary and will be the determining document on any question of policy.
What You Need to Know about the Business Service Center (BSC)

Effective January 3, 2011, the BSC began providing services for the MTA agencies in Human Resources, Finance and Information Technology.

You will contact the Customer Management Center (CMC) to make inquiries or request services related to your benefits, pension, FMLA, HR: Online job applications, screening of job applications, pre-employment communications, pre-employment testing, and enrollment of training, Payroll, Information Technology: PeopleSoft Access/Reports, etc., and HRIS: Employment verification, Disability Forms, Direct Deposit, Tax Forms, Change of Address, Garnishments, Child Support, and Personnel Records.

You will be able to go online via the BSC Portal (website) to download HR forms and view benefits information from your workplace or any computer connected to the Internet.

Here are the important BSC numbers and contact information:

- Hours: Monday – Friday, 8:30 AM – 5:00 PM
- Phone: 646.376.0123
- Website: www.mta-bsc.org
- Email (general): bscservice@mtabsc.org
- Fax (general): 212.852.8700
- Fax (IT forms): 212.852.8701
- Fax (invoices): 212.971.5060
- BSC Mail:  MTA Business Service Center:
  333 West 34th Street, 9th Floor
  New York, New York 10001-2402
INTRODUCTION
You are eligible for Health and Welfare benefits if you are a full-time employee.

Our benefits program provides flexibility, protection and value through:
- Health care benefits, including Medical, Vision and Dental plans; an Employee Assistance Program
- Welfare Benefits, including Basic and Optional Life, Dependent life, Basic and Optional Accidental Death and Dismemberment Insurance
- Disability benefits, including extended sick benefits and long term disability
- Flexible Spending Accounts, including a Health Care Account and Dependent Care Account
- Retirement benefits, including a retirement plan, 401(k) and 457 savings plans

This summary highlights the plans in our benefits program.

WHEN COVERAGE BEGINS
The coverage effective dates for certain benefits are not the same:
- Medical benefits begin on the 1st of the month following your date of hire.
- Life Insurance and Disability coverage begins on your date of hire.
- Flexible Spending Accounts begins 90 days after date of hire.
- Dental and Vision benefits begin on the 1st of the month following 1 year of employment.

COSTS
How much you pay for benefits will depend on the category you select. You may select from one of the following categories:

1. Employee only
2. Family

These coverage categories give you flexibility in tailoring your benefits to meet your personal needs.

WHO IS ELIGIBLE?
- Your spouse
- Your domestic partner. Contact the MTA Business Service Center at 646-376-0123 for complete information on eligibility and a domestic partnership package.
- Your child(ren) who are under 26 years of age – Medical only.
- Your unmarried dependents up to age 19 and older up to age 25 if they are full-time students at an accredited secondary, preparatory school, or college for dental and vision coverage.
- Your dependents if they are permanently disabled and incapable of self-support. Contact the MTA Business Service Center at 646-376-0123 for complete information on eligibility.

WHAT DOCUMENTS DO I NEED TO ENROLL MY DEPENDENTS
All new enrollees and dependents must provide a copy of proof of eligibility to enroll in all plans for all dependents:
- Marriage Certificate
- Birth Certificate
- Social Security Card
- Student Verification (unmarried dependents 19 and older up to age 25)
- Most recent tax return showing married filing jointly (required if married over 1 year). If tax document is not available, current joint bank statement, mortgage statement or homeowners’ policy may be provided.

A Life Event results in changes to your benefits which allow you to add or delete a dependent due to the following:
- Gain of a dependent (Marriage; birth/adoption)
- Loss of a dependent (Death of spouse or child; divorce; child loses dependent status)

You MUST notify MTA Business Service Center within (30) days of the life event, otherwise, a late enrollment waiting period will be imposed for enrollment forms received after the (30) day deadline. Contact MTA Business Service Center at 646-376-0123 or see your Plan document for details.

A change in employment status results in changes to your benefits (Part-time to full-time; full-time to part-time; termination)
ANNUAL MEDICAL OPTION TRANSFER PERIOD

Each year employees may switch health plans during the Medical Option Transfer Period. You can change from Empire Plan to an HMO, an HMO to the Empire Plan, or from one HMO to another HMO. This takes place during the month of December to become effective on January 1 of the following year. Contact the MTA Business Service Center for an option transfer enrollment form, otherwise you will remain with the health plan you currently have.

OPT-OUT INCENTIVE PROGRAM

If you are covered under your spouse’s medical plan you may elect to opt-out of medical coverage. The Opt-Out Incentive Program runs on a calendar year basis (January 1 through December 31). If you opt out of medical coverage and are eligible for employee only coverage or covered under your spouse’s/domestic partner’s MTA provided medical plan you will receive $1,000; $3,000 if you are eligible for family coverage and not covered under a MTA provided medical plan. Payment is subject to all applicable federal, state and local taxes.

You will need to complete an opt-out incentive form during the opt-out period in order to receive the incentive. The incentive may be paid to you or may be roll into your 401(k) or 457 account.

Providing false or misleading information about eligibility for coverage or benefits is considered fraud. Employees who fraudulently provide false or misleading information about eligibility for coverage or benefits are held financially and legally responsible for any benefits paid and are subject to disciplinary action up to and including termination of employment.
NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP)

You are among the 1.1 million enrollees and dependents that make the New York State Health Insurance Program (NYSHIP) one of the largest group health insurance programs in the United States. NYSHIP provides valuable medical benefits for you and your eligible dependents through two different options: The Empire Plan, an indemnity plan with some managed care features, or health care from a participating Health Maintenance Organization (HMO) in your area. Both options provide medical and surgical care, hospital expense benefits, mental health and substance abuse benefits. Both options also provide prescription drug coverage.

Universal phone number for ALL Empire Plan coverages: 877-7-NYSHIP (877-769-7447)

EMPIRE PLAN

The Empire Plan lets you choose between in-network and out-of-network providers each time you need medical care.

IN-NETWORK PROVIDERS

You pay $20 for office visits and there are no claim forms to fill out.

NON-NETWORK PROVIDERS

If you use a non-participating provider, for medical/surgical and mental health and substance abuse services, The Empire Plan has a combined annual deductible of:

- $1,000 per employee
- $1,000 enrolled spouse/domestic partner
- $1,000 dependent children combined

The combined deductible must be met before covered services under the Basic Medical Program and non-network expenses under the Mental Health and Substance Abuse Program can be reimbursed.

The Empire Plan pays 80% of Reasonable and Customary charges for covered services after the annual deductible has been met. You are responsible for the remaining 20% of the charges.

The Empire Plan has a combined annual coinsurance maximum of:

- $3,000 per enrollee
- $3,000 per enrolled spouse/domestic partner
- $3,000 per all dependent children combined

After you reach the combined annual coinsurance maximum, The Empire Plan will pay 100% of Reasonable and Customary charges.

BASIC MEDICAL PROGRAM

UNITED HEALTHCARE (Group #30500) – 877-769-7447

You must call The Empire Plan at 877-769-7447 PROSPECTIVE Procedure Review (PPR) and choose United Healthcare if you or one of your enrolled dependents is scheduled for an outpatient MRI, MRA, CT, CAT, PET and Nuclear Medicine tests unless you are having the test as an inpatient in a hospital.

If you do not call The Empire Plan before an elective (non-emergency) procedure and United Healthcare’s review does not confirm that the procedure was medically necessary, you will be responsible for the full charges.

Always confirm the provider’s participation before you receive services.

If you choose a doctor or laboratory that is a participating provider you are responsible for a copayment of $20.

Note: You can be charged a maximum of 2 copayments per visit when you combine a doctor’s visit with a laboratory procedure.

A list of participating providers can be obtained by calling United HealthCare directly at 877-769-7447 or by using the website at http://www.empireplanproviders.com.

The lifetime maximum benefits under the basic medical program are unlimited.

HOSPITAL BENEFITS PROGRAM

EMPIRE BLUE CROSS BLUE SHIELD - 877-769-7447

No copayment, and no deductible for 365 days inpatient hospitalization.

- $20 copayment for outpatient physical therapy
- $40 copayment for outpatient diagnostic radiology, mammography, and diagnostic laboratory tests
- $70 copayment for emergency room visits

PRE-ADMISSION CERTIFICATION

You must pre-certify prior to an inpatient admission to a hospital. You must call within 48 hours after being admitted on an emergency basis.
MANAGED PHYSICAL NETWORK (MPN) - 877-769-7447
CHIROPRACTIC CARE AND PHYSICAL THERAPY

You pay a $20 copayment for each office visit to a MPN provider. Always confirm the provider’s participation before you receive services.

If you do not use a MPN provider, you must meet an annual deductible of:

- $250 employee
- $250 enrolled spouse/domestic partner
- $250 dependent children combined

These Deductibles are separate from any other medical deductibles.

If you do not use a MPN provider, the Empire Plan pays up to 50% of the network allowance. You are responsible for the remaining charges.

HOME CARE ADVOCACY PROGRAM - (HCAP) - 877-769-7447

HOME CARE SERVICES, SKILLED NURSING SERVICES & DURABLE MEDICAL SUPPLIES

To receive a paid-in-full benefit, you must call HCAP to pre-certify. HCAP will help you make arrangements for covered services, durable medical equipment and supplies, including insulin pumps, Medijectors, and nebulizers. For diabetic supplies (except insulin pumps and Medijectors) call The Empire Plan Diabetic Supplies Pharmacy at 888-306-7337. For ostomy supplies, call Byram HealthCare Centers at 800-354-4054.

If you do not use HCAP, after you have met the basic medical deductible of $375, the Empire Plan pays up to 50% of the network allowance.

MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM
OPTUM HEALTH BEHAVIORAL SOLUTIONS (OptumHealth)- 877-769-7447

Mental Health benefits are unlimited when medically necessary.

OUTPATIENT COPAYMENT - NETWORK COVERAGE

The copayments:

- $20 - mental health
- $20 - substance abuse

The maximum benefit for outpatient network coverage is unlimited when medically necessary.

INPATIENT- NETWORK COVERAGE

If you do not use a MPN provider, the Empire Plan pays up to 50% of the network allowance. You are responsible for the remaining charges.

MYUHC.COM

You may view your most recent medical claims or search for a claim within the past eighteen months. You can also view and print your Explanation of Benefits (EOB). To register for your personal account:

- Log on to the Internet website at www.myuhc.com

PRESCRIPTION DRUG PROGRAM
MEDCO/UNITED HEALTHCARE - 877-769-7447

UP TO 30 DAY SUPPLY FROM A PARTICIPATING RETAIL PHARMACY OR THROUGH MEDCO BY MAIL

<table>
<thead>
<tr>
<th>Level 1 or most Generic drugs</th>
<th>Level 2 Preferred Drugs or Compound Drugs</th>
<th>Level 3 Non Preferred Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5 copayment</td>
<td>$25 copayment</td>
<td>$45 copayment</td>
</tr>
</tbody>
</table>

31 To 90 DAY SUPPLY FROM A PARTICIPATING RETAIL PHARMACY

<table>
<thead>
<tr>
<th>Level 1 or most Generic drugs</th>
<th>Level 2 Preferred Drugs or Compound Drugs</th>
<th>Level 3 Non Preferred Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 copayment</td>
<td>$50 copayment</td>
<td>$90 copayment</td>
</tr>
</tbody>
</table>

31 To 90 SUPPLY THROUGH THE EMPIRE PLAN “MEDCO MAIL SERVICE”

<table>
<thead>
<tr>
<th>Level 1 or most Generic drugs</th>
<th>Level 2 Preferred Drugs or Compound Drugs</th>
<th>Level 3 Non Preferred Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5 copayment</td>
<td>$50 copayment</td>
<td>$90 copayment</td>
</tr>
</tbody>
</table>

For envelopes and refill orders call The Empire Plan at 877-769-7477 and choose The Empire Plan Prescription Drug Program.

For the most current list of preferred drugs call The Empire Plan Prescription Drug Plan at 877-769-7447 or visit www.cs.ny.gov.

NON-NETWORK PHARMACY

If you do not use a participating pharmacy, you must submit a claim to Medco. Contact Medco at 877-769-7447 for claim forms.
DRUGS REQUIRING PRIOR AUTHORIZATION

For the most current list of drugs requiring prior authorization, call The Empire Plan Prescription Drug Plan or visit www.cs.ny.gov.

EMPIRE PLAN - HEARING AID BENEFIT

Hearing aids, including evaluation, fitting and purchase are covered up to a total maximum of $1,500 per ear once every four years. Children age 12 and under are eligible to receive a benefit of up to $1,500 for per ear once every two years when the child’s hearing has changed, and the existing hearing aid can no longer compensate. The hearing aid benefit is not subject to the annual deductible or coinsurance. All expenses related to the hearing aid benefit are submitted to United HealthCare.

HEALTH MAINTENANCE ORGANIZATIONS (HMO’S)

A Health Maintenance Organization (HMO) is a health delivery system organized to deliver health care services in a geographic area. An HMO provides a predetermined set of benefits through a network of selected physicians, laboratories and hospitals for a prepaid premium. You and your enrolled dependents may only have coverage or services received from your HMO network. You must contact your HMO regarding emergency services.

NEW YORK STATE HEALTH INSURANCE PROGRAM HMO’S

Aetna
Capital District Physician’s Health
Empire BlueCross BlueShield
GHI HMO
HIP Health Plan of NY
MVP Health Plan
UHC Oxford
Please refer to the NYSHIP Choices booklet for details on the above HMOs.

MTA METRO-NORTH RAILROAD
CONNECTICUT HMO’S

ConnectiCare
UHC Oxford

Please refer to the ConnectiCare and UHC Oxford summaries for plan information.

EARLY RETIREE REINSURANCE PROGRAM (ERRP) NOTICE

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants’ premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursement in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retirement Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.
DENTAL INSURANCE (METLIFE – Group #94072)

When you and/or your eligible dependents receive care from a network dentist, the Plan will reimburse at a higher percentage as shown. Network dentists are part of the Preferred Dentist Program (PDP).

The dental plan covers the following services:

<table>
<thead>
<tr>
<th>Dental Care</th>
<th>In-Network</th>
<th>Non-Network</th>
<th>Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>- 0 -</td>
<td>$ 50 – $150</td>
<td>$2,500</td>
</tr>
<tr>
<td>Preventive – Type A</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Restorative - Type B*</td>
<td>80%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Prosthetic - Type C*</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Orthodontic - Type D** (Eligible dependents up to age 19 only)</td>
<td>80%</td>
<td>60%</td>
<td>$2,300 Lifetime</td>
</tr>
</tbody>
</table>

* Annual Deductible with a non-network dentist for Type B & C.

** There is a separate $50 deductible for ORTHODONTIA with a non-network dentist.

PREFERRED DENTIST PROGRAM

The Preferred Dentist Program is a network of dentists who have contractually agreed with MetLife to accept a reduced fee schedule. The reduction is between 15% and 20% less than their normal fees. You and/or your eligible dependents are not obligated to use a PDP dentist. Your dental coverage remains the same, however by using a PDP dentist, your ‘out-of-pocket’ costs will be lower for certain services. You will use the same dental claim form and submit your dental expenses to the address on the back of the claim form. Contact the MTA Business Service Center at 646-376-0123 to request claim forms or visit their website at bcservice@mtabsc.org.

To obtain a list of dentists in the Preferred Dentist Program from MetLife call 800-942-0854 or visit MetLife’s website at http://www.metlife.com/dental.

VISION INSURANCE (EYEMED VISION CARE – Group #9746595)

The vision plan offers Network and Non-Network Providers. If you use a provider that participated in Eyemed Vision Care, most services will be covered. Both disposable and hard lens contacts are reimbursable expenses.

You must save receipts for disposable contacts and submit them under one claim when total expenses equal $100. Network providers may bill you for the contact lens expenses that exceed the $100 limit. The Plan provides for Vision Care visits once per calendar year. The Plan will not cover contact lenses prescribed for cosmetic purposes.

To obtain a listing of providers call 866-799-9984 or log onto their website www.eyemedvisioncare.com.

MTA FLEXIBLE SPENDING ACCOUNTS - (FSA) – P&A Group

The FSA allows you to set aside pre-tax dollars for eligible health and/or dependent care expenses.

- Health Care Account – you can use this account to pay for health care expenses not covered or fully reimbursed under another health care plan – for example copayments, deductible, eyeglasses etc. The annual maximum contribution for the Health Care account is $2,500.

- Dependent Care Account – you can use this account to pay for certain day care expenses for your eligible dependents so you and your spouse can both work. The annual maximum contribution for the Dependent Care account is $5,000.

The deductions for both the Health Care and Dependent Care accounts are made weekly from your paycheck. The minimum annual contribution is $260 per year for each account.

All enrollees must re-enroll each year during open enrollment to maintain eligibility. Open enrollment occurs each year in November to be effective for January 1st of the next calendar year.
TERMINATION OF INSURANCE BENEFITS

Your coverage ends when you are no longer eligible for the following reasons.

Resignation/Termination

- If your employment ends on or before the 15th of the month, coverage ends the last day of the month in which you left.
- If your employment ends after the 15th of the month, coverage ends the last day of the following month except for any life insurance coverage which will end the end of the month in which you left.

Dismissal/Suspension/Removal from Service

Your coverage will continue until the end of the fourth month from the date last worked. (For example: if the last date worked is March 5, 2013, then the benefits extension is until July 31, 2013).

Furlough

Your coverage will continue until the end of the fourth month from the date last worked. (For example: if the last date worked is December 28, 2012, then the benefits extension is until April 30, 2013).

Medical Leave of Absence

Your coverage will continue for yourself and all dependents until the end of the calendar year following the calendar year of the date last worked. (For example: if the date last worked is October 21, 2012, then the benefits extension is until December 31, 2013). Coverage will continue for the employee only for another calendar year (For example: the benefits extension for the employee in the example is December 31, 2014).

Personal Leave of Absence/Absent without Leave (AWOL)

The end of the month following the date last worked.

Upon the termination of your coverage you will be giving the opportunity to continue your medical, dental vision and FSA coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA).

The BSC will also send you information on your conversion rights for any employee basic or supplemental life insurance coverage that may have been terminated.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Upon separation from MTA Metro-North Railroad, you are eligible to continue your medical, dental, vision and FSA coverage under COBRA at your own expense for up to 18 months. Enrollment and rate information will be mailed to your home address by the COBRA administrator SHPS.

You are responsible for notifying the BSC for any dependents who are no longer eligible for coverage within 30 days of the qualifying event date. Upon termination of coverage your dependent will also receive COBRA information from SHPS. For information and applications please call the MTA Business Service Center at 646-376-0123.

MNRR HEARING AID BENEFIT

ACTIVE EMPLOYEES ONLY Hearing aids, including evaluation, fitting, and purchases are covered up to a total maximum of $1,000 ($500 per ear) once every three years. All expenses related to the hearing aid benefit are submitted to MNRR. MNRR will reimburse you directly and not the provider. Call the MTA Business Center at 646-376-0123 for a Hearing Aid claim form.

MTA METRO-NORTH ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE - METLIFE

The basic AD&D insurance pays a benefit of $8,000 to your designated beneficiary. This benefit is paid due to an accidental death, and a partial benefit is paid based on the type of dismemberment.

MTA METRO NORTH OPTIONAL LIFE INSURANCE - METLIFE

This is an opportunity to purchase optional life insurance. The life insurance benefit amounts are in increments of $25,000 with a minimum of $25,000 to a maximum of $250,000 for all crafts except ACRE. ACRE Represented employees are able to purchase a minimum of $50,000 to a maximum of $500,000. You may purchase the optional life insurance coverage within 31 days from your date of hire without providing evidence of insurability if the amount of your election does not exceed $50,000.

If you are electing to enroll 31 days after your date of hire and/or the amount you are electing to purchase exceeds $50,000 you must complete a MetLife Statement of Health questionnaire. MetLife will review your application and notify you of their determination. If approved you will be enrolled in the amount of life insurance MetLife approved. If you would like to apply for this benefit you must contact the BSC for an application.
The cost for optional life insurance is based on the following:

<table>
<thead>
<tr>
<th>Age</th>
<th>Rates/$1,000 of Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>0.108</td>
</tr>
<tr>
<td>30-34</td>
<td>0.144</td>
</tr>
<tr>
<td>35-39</td>
<td>0.171</td>
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<tr>
<td>40-44</td>
<td>0.216</td>
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<td>45-49</td>
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<tr>
<td>50-54</td>
<td>0.576</td>
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<tr>
<td>55-59</td>
<td>0.909</td>
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<tr>
<td>60-64</td>
<td>1.404</td>
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<tr>
<td>65-69</td>
<td>2.286</td>
</tr>
<tr>
<td>70-74</td>
<td>3.519</td>
</tr>
<tr>
<td>75-79</td>
<td>5.418</td>
</tr>
</tbody>
</table>

**METLIFE SHORT TERM DISABILITY BENEFIT**

After you have exhausted your sick days, you are eligible to apply for short term disability benefits. The application for short-term disability benefits under MetLife, and Railroad Retirement sickness benefits, can be requested from the MTA Business Service Center at 646-376-0123. Each application requires a Physician’s certification concerning the illness. The Railroad Retirement application is sent directly to the Railroad Retirement Board, and the MetLife application is forwarded to the BSC. The short-term disability benefit is for a maximum of 52 weeks. MetLife may periodically request additional information from your doctor.

**MTA DEFINED BENEFIT PENSION PLAN FOR METRO-NORTH EMPLOYEES**

Metro-North participants of the MTA Defined Benefit Pension Plan (DB Plan), both represented and non-represented, are eligible for an unreduced retirement benefit at:

- age of 62 with the completion of five years of defined benefit pension plan credited service; or
- age 55 with the completion of thirty years or more of credited defined benefit pension plan service or
- a permanently reduced basis at age 55 if the participant has at least ten years of credited defined benefit pension plan service.

The DB Plan provides for death and disability benefits.

Employees must complete five years of credited service in order to be considered vested in the DB Plan. If an employee leaves Metro-North with less than five years of credited service, all rights to a benefit from the plan are forfeited.

The plan requires a mandatory deduction of 3% of all represented participants’ gross salary on a weekly basis.

**Other features of the plan:**

- A defined pension benefit is based on the final average salary and years of credited service
- An active employee participating in the plan is eligible for a death benefit of one year’s salary after one year of service, two times annual salary after two years of service and three times annual salary after three years of service (subject to reductions after age 60). However, for a period of 36 months from ratification of your respective union contract, additional benefits may apply.
- A participant is eligible to receive a reduced retirement allowance as early as age 55 (certain restrictions apply)
- A participant is eligible to apply for a disability retirement (certain criteria must be met)
- A participant is eligible for a post retirement death benefit that remains in effect for participant’s lifetime (subject to a calculation)
- A participant may select from several types of payment options that will provide for his/her beneficiary upon death of participant
- Regardless of the option elected, a participant will receive a payment from the MTA Defined Benefit Pension Plan for the participant’s lifetime

If you have any questions about the MTA DB Plan for Metro-North Employees, call the MTA Business Service Center at 646-376-0123.

**MTA METRO-NORTH DEFINED CONTRIBUTION PENSION PLAN FOR AGREEMENT EMPLOYEES**

Participation in the Metro-North Commuter Railroad Defined Contribution Pension Plan for Agreement Employees is available only to employees who declined participation in the MTA Defined Benefit Pension Plan during 2007 union contract renewals. MTA Metro-North Railroad automatically makes employer contributions equal to 4% of your gross earnings on a weekly basis to the MTA 401(K) Plan. When you have 19 years of MTA Metro-North Railroad service, the employer contribution increases to 7%.
Vesting is 5 years of service, and normal retirement age is 62. You may also retire

- at age 60 with 15 years of participation in the plan
- or
- at age 55 with 30 years of participation in the plan.

MTA METRO-NORTH BASIC GROUP LIFE INSURANCE - METLIFE

Participants of the Metro-North Commuter Railroad Agreement Defined Contribution Pension Plan are covered under the basic group life insurance benefit with MetLife Insurance Company. In the event of your death, the plan pays $100,000 to your designated beneficiary. Please be sure to keep your designated beneficiary on file with the MTA Business Service Center’s Employee Benefits Department.

MTA 401(k) PLAN
MTA 457 PLAN

The 401(k) Plan and the 457 Plan are tax deferred plans which allow you to set money aside for retirement. Under the terms of the 401(k) Plan and 457 Plan, you are allowed to defer current income for retirement through weekly payroll deductions while reducing your tax liability.

Participation in one or both [401(k) and 457] plans allows you to tax-defer up to a maximum of $17,500 for 2013.

The plans will allow contributions up to an additional $5,500 if you are age 50 or older by the end of calendar year

The 457 Plan has two different types of catch-up options.

The “regular” 457 Plan option allows you to contribute up to $35,000 in 2013. The amount that you can contribute under "regular" catch-up will depend upon contributions you could have made in previous years but did not. Alternatively, you may contribute under the “Age 50 +” catch up provision. You may not contribute under both catch up provisions in the same calendar year.

For additional information or to enroll contact Prudential at 877-756-4682 or visit the website at http://www.prudential.com/mta.

US RAILROAD RETIREMENT ACT

The Act provides retirement and disability benefits for qualified railroad employees.

TIER I AND MEDICARE TAX:

7.65% tax rate up to a maximum compensation of $113,700. Included in Tier I is 1.45% for Medicare which continues to be deducted after the $113,700 is reached.

TIER II TAX:

3.9% tax rate up to a maximum compensation of $84,300. You must complete five years of creditable service to vest under Tier II. If you leave with less than five years of credited service with MTA Metro-North Railroad or any other US Railroad, you forfeit all rights to a benefit from Tier II.

RAILROAD UNEMPLOYMENT INSURANCE ACT (RUIA)

The Act provides unemployment insurance and sickness benefits. The Railroad Retirement Board must be contacted at 877-772-5772 to apply for benefits. Employees who begin working for a railroad in 2012 will not be eligible for unemployment or sickness benefits until July 1, 2013, provided they have a minimum of five months of creditable service in 2012. The “Benefit Year” runs from July 1 to June 30. All benefits paid during that time are based on the previous calendar year.

MTA METRO-NORTH EMPLOYEE ASSISTANCE PROGRAM (EAP) 212-340-2792

EAP is a confidential counseling service that helps employees deal with personal problems that may affect job performance and well-being. Some of the problems EAP can assist you with include emotional problems, marriage and family problems, substance abuse problems, stress, grief/bereavement issues, and critical incident debriefings after traumatic accidents/incidents. Contact EAP for assistance.

BEREAVEMENT LEAVE

Bereavement leave, not in excess of three (3) consecutive workdays, following the date of death will be allowed in case of death of an employee’s brother, sister, parent, child, spouse or spouse’s parent, step-children, grandparents and grandchildren.

JURY DUTY LEAVE

An employee will receive paid leave for jury duty with the submission of a copy of the notice to the Treasury and Payroll Departments. An employee who is called to serve on New York State Juries will be required to check the “yes” box on the court questionnaire inquiring as to their status as a “State of Local Government Employee.” The “yes” answer will waive payment of jury fees paid by the court. This change will not alter the employee’s responsibility for furnishing proper documentation from the court attesting to the days actually served.
MTA Metro-North agreement employees will observe the following holidays in 2013.

<table>
<thead>
<tr>
<th>HOLIDAYS</th>
<th>OBSERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Year's Day</td>
<td>Tuesday, January 1</td>
</tr>
<tr>
<td>Martin Luther King Jr. Day</td>
<td>Monday, January 21</td>
</tr>
<tr>
<td>Presidents Day</td>
<td>Monday, February 18</td>
</tr>
<tr>
<td>Good Friday*</td>
<td>Friday, March 29</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>Monday, May 27</td>
</tr>
<tr>
<td>Independence Day</td>
<td>Thursday, July 4</td>
</tr>
<tr>
<td>Labor Day</td>
<td>Monday, September 2</td>
</tr>
<tr>
<td>Veterans Day**</td>
<td>Monday, November 11</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>Thursday, November 28</td>
</tr>
<tr>
<td>Day after Thanksgiving Day*</td>
<td>Friday, November 29</td>
</tr>
<tr>
<td>Christmas Eve Day</td>
<td>Tuesday, December 24</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>Wednesday, December 25</td>
</tr>
<tr>
<td>New Year's Eve Day*</td>
<td>Tuesday, December 31</td>
</tr>
</tbody>
</table>

*Not a Holiday for all crafts, refer to your collective bargaining agreement
**Legal Holiday for qualifying veterans

Note: Not all unions receive the same holidays. Please refer to your collective bargaining agreement.

LIFECARE- WORK/LIFE SERVICES AND DISCOUNTS

Lifecare is a phone/internet service that provides information and referrals that support your “personal life” needs such as childcare, eldercare and pet care. This service is free to employees and their dependents. Lifecare provides educational materials, PDF downloads, web conferences, research and referrals for many personal needs including:

- Childcare
- Adult care options and services for seniors
- Prenatal care and options
- Summer care for children/teens
- Children with special needs
- Schools and academic services including colleges and academic financial aid services
- Adoption services
- Financial services (tax assistance, mortgages, debt management, etc.)
- Legal services
- Health and wellness
- Convenience/concierge services (chore services, moving, etc.)

- Discounts for various goods and services (computers, travel, movies, etc.)

To use this service, call (800) 873-4636 (or (800) 873-1322 for hearing impaired), or visit the website at http://www.lifecare.com/ or the MNR Benefits intranet site. For new users to register online, use registration code mnr; the member ID is your 6 digit employee ID number. Lifecare services are free, but employees are responsible for any fees associated with the services employees elect to use.

COLLEGE SAVINGS PROGRAM- 529 PLANS

New York and Connecticut have tax-advantaged savings programs available to you through convenient weekly payroll deductions. To participate, please contact the savings program of your choice as follows:

- New York College Savings Program: toll free 1-877-NYSAVES (Mon. – Fri. 8am to 11pm) or http://www.nysaves.org

PREMIUM TRANSIT CHEK

You can elect up to $125/month in pre-tax deductions for commutation expenses such as the Metrocard or the TransitChek QuickPay Card (a debit card for transit tickets/passes and commuter parking at participating transit and parking locations that accept credit/debit cards). In addition to the current $125 pre-tax deduction for commutation expenses, up to $240/month may be deducted pre-tax for commuter parking benefits. Your total monthly deductions for both pre-tax and post-tax deductions cannot exceed $1,000.

Contact the Premium TransitChek Program at http://www.mytransitcheck.com or 1-866-823-3248 (Mon. to Fri., 8am to 5pm) or Customer Service Representatives at 1-877-440-4407, M-F, 9am-5pm.
HEALTH CLUB MEMBERSHIPS

Memberships at group rates through weekly payroll deductions are available to all employees in active pay status. Employees can join during open enrollment periods (twice a year in January or June/July). If you miss open enrollment, you can get on a "waiting list" and will be contacted when a membership is available for transfer. Choices include:

<table>
<thead>
<tr>
<th>CLUB</th>
<th>TERM</th>
<th>INITIATION FEE</th>
<th>WEEKLY PAYROLL DEDUCTION</th>
<th>DIRECT PAY</th>
<th>TOTAL</th>
<th>FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYH&amp;RC</td>
<td>24 months</td>
<td>NO</td>
<td>$14.43</td>
<td>N/A</td>
<td>$1,500.00</td>
<td>Yes</td>
</tr>
<tr>
<td>NYSC</td>
<td>24 months</td>
<td>NO</td>
<td>$14.81</td>
<td>N/A</td>
<td>$1,540.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Ballys Total Fitness</td>
<td>12 months</td>
<td>NO</td>
<td>$ 3.83</td>
<td>N/A</td>
<td>$ 199.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Equinox - Select</td>
<td>12 months</td>
<td>NO</td>
<td>$27.40</td>
<td>N/A</td>
<td>$1,416.00</td>
<td>Yes</td>
</tr>
<tr>
<td>Equinox-Corporate Access</td>
<td>12 months</td>
<td>NO</td>
<td>$32.07</td>
<td>N/A</td>
<td>$1,668.00</td>
<td>Yes</td>
</tr>
<tr>
<td>YMCA (Manhattan and Long Island) *varies by location</td>
<td>12 months</td>
<td>50%</td>
<td>N/A</td>
<td>20% off</td>
<td>N/A</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Rates are subject to change. Please contact the MTA Business Service Center at 646-376-0123 for additional information.

The official plan description and official company policy takes precedence over this summary and will be the determining document on any question of policy.
SUMMARY OF TELEPHONE NUMBERS

Empire Plan

United Healthcare - Medical Program

Empire Blue Cross Blue Shield - Hospital Program

United Healthcare-Medco - Prescription Drug Program

Optum Health - Mental Health and Substance Abuse Program

Home Care Advocacy Program (HCAP) - Home Care Equip/Skilled Nursing Program

Managed Physical Network/Physical Therapy (MPN) – Chiropractic Care and Physical Program

NY State Dept. of Civil Service
800-833-4344

LabCorp
888-522-2677

HMO's - (Health Maintenance Organizations)

Aetna
800-323-9930..................http://www.aetna.com

Capital District Physicians (CDPHP)
800-777-2273..................http://www.cdphp.com

ConnectiCare
800-251-7722..................http://www.connecticare.com

Empire HMO
800-453-0113..................http://www.empireblue.com

GHI HMO Select
877-244-4466..................http://www.ghihmo.com

HIP of NY
800-447-8255..................http://www.hipusa.com

MVP Health Plan
888-687-6277..................http://www.myphealthcare.com

UHC Oxford
800-444-6222..................http://www.oxfordhealth.com

Dental

MetLife (Group #94072)
800-942-0854..................http://www.metlife.com/dental

Preferred Dentist Hotline (PDP’s)
800-474-7371

Vision

Eyemed Vision Care (Group #9746595)
866-799-9984..............http://www.eymedvisioncare.com

Other Service Numbers

US Railroad Retirement Board

Prudential
877-756-4682..................http://www.prudential.com/mta

P&A Group (FSA)
800-688-2611..................http://www.padmin.com

LifeCare
800-873-4636..................http://www.lifecare.com

Dependent Care Counseling
800-873-4636

EAP (Employee Assistance Program)
212-340-2792

MTA Business Center
646-376-0123............http://www.bscservice@mtabsc.org
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your other costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>There are no other specific deductibles.</td>
<td>You don't have to meet <strong>deductibles</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>No</td>
<td>There’s no limit on how much you could pay during a policy period for your share of the cost of covered services.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>This plan has no out-of-pocket limit.</td>
<td>Not applicable because there’s no <strong>out-of-pocket limit</strong> on your expense.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the insurer pays?</td>
<td>No</td>
<td>The chart starting on page 2 describes any limits on what the insurer will pay for <strong>specific</strong> covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.ConnectiCare.com">www.ConnectiCare.com</a> or call 1-800-251-7722 for a list of participating providers and hospitals.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, preferred, or participating <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don't need a referral to see a specialist.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called **balance billing**)
- The plan may encourage you to use **In-network providers** by charging you lower **deductibles, copayments**, and **coinsurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your cost if you use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 Copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$15 Copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$15 Copayment per visit for chiropractor</td>
<td>Not covered for chiropractor up to 20 visits per year</td>
</tr>
<tr>
<td>Preventive care / screening / immunization</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Xray: $10 Copayment per visit, Lab: No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td>Imaging (CT / PET scans, MRIs)</td>
<td>$75 Copayment per visit</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
## Summary of Benefits and Coverage

**What this Plan Covers & What it Costs**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an In-network Provider</th>
<th>Your cost if you use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$10 Copayment (retail); $20 Copayment (mail order)</td>
<td>Not covered (retail); Not covered (mail order)</td>
<td>Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription)</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20 Copayment (retail); $40 Copayment (mail order)</td>
<td>Not covered (retail); Not covered (mail order)</td>
<td>Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription)</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$35 Copayment (retail); $70 Copayment (mail order)</td>
<td>Not covered (retail); Not Covered (mail order)</td>
<td>Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription)</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Varies based on above drug categories</td>
<td>Not covered</td>
<td>Covers up to a 30 day supply (retail prescription); 90 day supply (mail order prescription)</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Member cost</td>
<td>Not covered</td>
<td>-----none-----</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Member cost</td>
<td>Not covered</td>
<td>-----none-----</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>$50 Copayment per visit</td>
<td>$50 Copayment per visit</td>
<td>-----none-----</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Member cost</td>
<td>No Member cost</td>
<td>-----none-----</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 Copayment per visit</td>
<td>$25 Copayment per visit</td>
<td>-----none-----</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Member cost</td>
<td>Not covered</td>
<td>-----none-----</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Member cost</td>
<td>Not covered</td>
<td>-----none-----</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-251-7722 or visit us at www.ConnectiCare.com.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-251-7722 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an In-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 Copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$15 Copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you become pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No Member Cost</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 Copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Member cost</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$10 Copayment per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>25% Discount</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Applicable</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
</tbody>
</table>

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If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-251-7722 to request a copy.
Cosmetic Surgery  
Dental Care  
Habilitation Services  
Non-emergency care when traveling outside the U.S.  
Private-duty nursing  
Routine hearing tests  
Weight loss programs (discounted rate)

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery  
- Hearing aids (may be covered with limitations)  
- Routine eye care  
- Chiropractic care  
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-251-7722. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

ConnectiCare Member Appeals, PO Box 4061, Farmington, CT 06034-4061 or 1-800-251-7722 or Facsimile 1-800-319-0089
Connecticut Residents: CT State Department of Insurance at 1-800-203-3447 or www.ct.gov/cid/site/default.asp
Massachusetts Residents: MA Division of Insurance at 1-877-563-4467 or www.mass.gov/ocabr/government/oca-agencies/doi-lp/

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-251-7722.
Polish (Polski): Pomoc w języku polskim jest dostępna pod numerem telefonu 1-800-251-7722.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Table: Having a baby

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount Owed to Providers</th>
<th>Plan Pays</th>
<th>Patient Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
<td>$2,100</td>
<td>$200</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
<td></td>
<td>$180</td>
</tr>
</tbody>
</table>

Table: Managing type 2 diabetes

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount Owed to Providers</th>
<th>Plan Pays</th>
<th>Patient Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
<td></td>
<td>$880</td>
</tr>
</tbody>
</table>

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-390-3522.

Questions: Call 1-800-251-7722 or visit us at www.ConnectiCare.com.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-251-7722 to request a copy.
Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don’t include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and are not specific to a particular geographic area or health plan.
- Patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

Does the Coverage Example predict my own care needs?
- No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is and many other factors.

Does the Coverage Example predict my future expenses?
- No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
- Yes. When you look at the Summaries of Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as co-payments, deductibles and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-251-7722 to request a copy.

Coverage Period: 01/01/2013 to 12/31/2013
Coverage for: Family | Plan Type: HMO
### Benefit Coverage

**Financial Coverage**

<table>
<thead>
<tr>
<th>Category</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible:</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket:</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>(including Deductible)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Maximum Lifetime Benefit per Member</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Financial Accumulation Period:</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**Preventive Care**

- **Adult Preventive Care**: No Charge
- **Infant and Pediatric Preventive Care**: No Charge
- **Preventive Dental for Children (Through age 12)**: No Charge

**Outpatient Care**

- **Primary Care Physician Office Visits**: $15 copay per visit
- **Specialist Office Visits**
- **Outpatient Facility Surgery**
- **Laboratory Services**: At Participating Laboratories: No Charge
- **MRS, MRAs, CT Scans, PET Scans and Ultrasound**
- **Radiology Services**

**Hospital Care**

- **Physician's and Surgeon's Services**: No Charge
- **Semi-Private Room and Board**: No Charge
- **All Drugs and Medication**: No Charge

**Emergency Care**

- **Ambulance Service When Medically Necessary**: No Charge
- **At Hospital Emergency Room**
  - (If member is admitted to the hospital, notification is required.)
  - Emergency Care in Urgi-Center: $15 copay per visit

**Maternity Care**

- **Prenatal and Post-Natal Care**: $15 copay per initial visit
- **Hospital Services for Mother and Child**: No Charge

**Skilled Nursing Facility**

- **30 Days per Calendar Year**: No Charge

**Hospice Care (210 Days combined Inpatient, Outpatient and Home Hospice)**

- **Inpatient Care**: No Charge
- **Outpatient Care**: No Charge
- **Home Hospice**: No Charge

**Home Health Care**

- **Home Care Visits - 80 Visits Per Calendar Year**: No Charge
- **Physician House Calls**: $15 copay per visit

**Substance Use Disorder Services**

- **Inpatient Rehabilitation**: No Charge
- **Outpatient Rehabilitation**: $15 copay per visit

**Mental Health Care**

- **Inpatient Care**: No Charge
- **Outpatient Facility**: $15 copay per visit
- **Office Visits**: $15 copay per visit
### BENEFIT COVERAGE

#### BENEFIT

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALLERGY CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Testing and Treatment*</td>
<td>$15 copay per visit</td>
</tr>
<tr>
<td><strong>ALTERNATIVE MEDICINE</strong></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$15 copay per visit</td>
</tr>
<tr>
<td>Naturopathic Care</td>
<td>$15 copay per visit</td>
</tr>
<tr>
<td><strong>SHORT TERM REHABILITATION</strong></td>
<td></td>
</tr>
<tr>
<td>60 Consec. Inpatient Days per Condition/Lifetime**</td>
<td>No Charge</td>
</tr>
<tr>
<td>60 Outpatient Visits per Condition/Lifetime</td>
<td>$15 copay per visit</td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>MEDICAL SUPPLIES</strong></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies When Medically Necessary</td>
<td>$15 copay per item</td>
</tr>
<tr>
<td><strong>INFERTILITY TREATMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Basic, Comprehensive and Advanced Infertility Services. (Covers all services in compliance with the CT Infertility Mandate)</td>
<td></td>
</tr>
<tr>
<td>Limits- Two cycle limit per lifetime for IVF, GIFT, ZIFT &amp; low tubal ovum transfer.</td>
<td></td>
</tr>
<tr>
<td>Three cycle limit per Lifetime for Intrauterine Insemination</td>
<td></td>
</tr>
<tr>
<td>Four cycle limit per Lifetime for Ovulation Induction</td>
<td></td>
</tr>
<tr>
<td>If Administered by ObGyn**</td>
<td>$15 copay per visit</td>
</tr>
<tr>
<td>Specialist Office Visit**</td>
<td>$15 copay per visit</td>
</tr>
<tr>
<td>Outpatient Facility Service**</td>
<td>No Charge</td>
</tr>
<tr>
<td>Inpatient Facility Service**</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>INFERTILITY MEDICATIONS-No Limit</strong></td>
<td>Covered subject to the applicable Prescription Drug Out-of-Pocket expense</td>
</tr>
<tr>
<td><strong>HEARING AIDS</strong></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS (Includes Oral Contraceptives)</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1***</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Tier 2***</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Tier 3***</td>
<td>$35 copay</td>
</tr>
</tbody>
</table>

#### DEPENDENT ELIGIBILITY:

Eligible dependents include the employee's spouse and dependent children until the child reaches age 26. Benefits discontinue at the end of the Calendar Year.

*Visits to an Oxford participating Specialist require an authorized referral from the member's PCP.*

**These services require precertification through Oxford. Members must call Oxford at 1-800-444-6222 at least 14 days in advance of request of treatment to request precertification. Out-of-network Urgent Care, when properly precertified may be paid at member's copay.*

**Mental health and substance use disorder services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.*

***Prescription medications ordered through the Mail Order Drug Program are subject to 2 applicable retail pharmacy copays.*

***The Prescription Drug Benefit is based on a Per Contract Year limit for any applicable deductibles and/or maximum limits.*

Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.

Refer to the Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, or, unless otherwise stated, dental services and vision correction services and supplies.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.
### Weekly Medical Insurance Contributions

<table>
<thead>
<tr>
<th>Code #</th>
<th>PLANS</th>
<th>INDIVIDUAL</th>
<th>FAMILY</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>NYS EMPIRE PLAN (All States)</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>210</td>
<td>Aetna (Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Westchester &amp; New Jersey)</td>
<td>$45.80</td>
<td>$184.43</td>
</tr>
<tr>
<td>310</td>
<td>CDPHP (Dutchess, Orange and Ulster counties)</td>
<td>$3.57</td>
<td>$15.30</td>
</tr>
<tr>
<td>280</td>
<td>Empire BlueCross BlueShield HMO (Upstate) (Columbia, Greene, Rensselaer, Schenectady &amp; Warren)</td>
<td>$0.00</td>
<td>$8.26</td>
</tr>
<tr>
<td>290</td>
<td>Empire BlueCross BlueShield HMO (Downstate) (Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk &amp; Westchester)</td>
<td>$33.00</td>
<td>$107.55</td>
</tr>
<tr>
<td>320</td>
<td>Empire BlueCross BlueShield HMO - Mid Hudson - (Dutchess, Orange, Putnam, Sullivan &amp; Ulster)</td>
<td>$33.96</td>
<td>$110.06</td>
</tr>
<tr>
<td>220</td>
<td>GHI HMO Select (Albany, Columbia, Delaware, Greene, Rensselaer, Saratoga, Schenectady, Warren &amp; Washington)</td>
<td>$2.57</td>
<td>$30.51</td>
</tr>
<tr>
<td>350</td>
<td>GHI HMO Select (Dutchess, Orange, Putnam, Sullivan &amp; Ulster)</td>
<td>$7.16</td>
<td>$38.59</td>
</tr>
<tr>
<td>050</td>
<td>HIP of New York (Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk &amp; Westchester)</td>
<td>$16.79</td>
<td>$40.78</td>
</tr>
<tr>
<td>060</td>
<td>MVP Health Plan (East) (Albany, Columbia, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren &amp; Washington)</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>330</td>
<td>MVP Health Plan (Central) (Broome, Cayuga, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga &amp; Tompkins)</td>
<td>$0.81</td>
<td>$7.71</td>
</tr>
<tr>
<td>340</td>
<td>MVP Health Plan (Mid-Hudson) (Dutchess, Orange, Putnam, Rockland, Sullivan &amp; Ulster)</td>
<td>$0.00</td>
<td>$4.78</td>
</tr>
<tr>
<td>222</td>
<td>UnitedHealthcare Oxford Health Plan (Connecticut, New Jersey &amp; New York)</td>
<td>$15.48</td>
<td>$47.63</td>
</tr>
<tr>
<td>333</td>
<td>ConnectiCare (Connecticut only)</td>
<td>$0.86</td>
<td>$2.44</td>
</tr>
</tbody>
</table>
## 2013 Medical Plan Copays
### In Network

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Office Copay</th>
<th>RX Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYS Empire Plan 001 (All States)</td>
<td>$20.00</td>
<td>$5/$25/$45</td>
</tr>
<tr>
<td>Aetna 210 (NYC, NJ, Nassau, Putnam, Suffolk, Rockland, Sullivan &amp; Westchester)</td>
<td>$20.00</td>
<td>$10/$20/$35</td>
</tr>
<tr>
<td>Capital District Physicians - Capital 063 (Columbia, Greene, Rensselaer, Schenectady &amp; Warren)</td>
<td>$20.00</td>
<td>$5/$30/$50</td>
</tr>
<tr>
<td>Capital District Physicians - 300 (Broome, Delaware, Essex &amp; Hamilton)</td>
<td>$20.00</td>
<td>$5/$30/$50</td>
</tr>
<tr>
<td>Capital District Physicians - 310 (Dutchess, Orange &amp; Ulster)</td>
<td>$20.00</td>
<td>$5/$30/$50</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield HMO UpState - 280 (Columbia, Greene, Rensselaer, Schenectady &amp; Warren)</td>
<td>$20.00</td>
<td>$10/$25/$50</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield HMO - Downstate - 290 (NYC, Rockland, Suffolk &amp; Westchester)</td>
<td>$20.00</td>
<td>$10/$25/$50</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield HMO - Mid Hudson - 320 (Dutchess, Orange, Putnam &amp; Ulster)</td>
<td>$20.00</td>
<td>$10/$25/$50</td>
</tr>
<tr>
<td>GHI HMO Select - 220 (Columbia, Delaware, Greene, Rensselaer, Schenectady &amp; Warren)</td>
<td>$20.00</td>
<td>$10/$20/$30</td>
</tr>
<tr>
<td>GHI HMO Select - 350 (Dutchess, Orange, Putnam, Rockland, Sullivan &amp; Ulster)</td>
<td>$20.00</td>
<td>$10/$20/$30</td>
</tr>
<tr>
<td>HIP of New York - 050 (NYC, Nassau, Suffolk &amp; Westchester)</td>
<td>$5.00</td>
<td>$5.00</td>
</tr>
<tr>
<td>MVP Health Plan East - 060 (Columbia, Green, Rensselaer &amp; Schenectady)</td>
<td>$25.00</td>
<td>$10/$30/$50</td>
</tr>
<tr>
<td>MVP Health Plan - Central - 330 (Broome, Delaware &amp; Tompkins)</td>
<td>$25.00</td>
<td>$10/$30/$50</td>
</tr>
<tr>
<td>MVP Health Plan - Mid Hudson - 340 (Dutchess, Orange, Putnam, Rockland, Sullivan &amp; Ulster)</td>
<td>$25.00</td>
<td>$10/$30/$50</td>
</tr>
<tr>
<td>United Healthcare Oxford - 222 (CT, NJ &amp; NY)</td>
<td>$15.00</td>
<td>$10/$20/$35</td>
</tr>
<tr>
<td>ConnectiCare - 333 (Connecticut Only)</td>
<td>$15.00</td>
<td>$10/$20/$35</td>
</tr>
</tbody>
</table>

*Prescription Drug = Level 1 / Level 2 / Level 3*