



Benefits Guide 2009



City of Hope™



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Understanding Your Benefits

Dear Valued Employee:

Welcome to your City of Hope Benefits Guide for 2009. This booklet has been created to provide you with an efficient way to obtain information and answers to your questions regarding your employee benefit plans.

Benefits and Employee Services will also provide you with educational tools and resources to help you better understand what benefits are offered to you and your family and how to get the most from these plans. Please take the time to understand your benefits better by utilizing all of these tools provided to you as a City of Hope employee.

New Hire Eligibility

All permanent employees working at least 20 hours per week, including lawful spouse, domestic partner and eligible dependent children.

Core Plans

Medical, Dental, Vision, Basic Life/AD&D, Short Term and Long Term Disability:

Effective on the first day of the month following 30 days of employment.

Flexible Spending Account:

Effective on the first day of the month following 30 days of employment.

Employee Assistance Plan:

Effective **immediately** upon employment.

Voluntary Plans

Term Life, AD&D, LTD, Cancer Insurance and Pet Insurance:

Effective on the first day of the month following 30 days of employment.

Dependent Eligibility Limitations

Medical, Dental & Vision:

Eligible children to age 25, regardless of student status.

The information contained in this booklet is only a summary of the covered benefits. Please refer to your Certificate of Coverage or your Summary Plan Description for a complete explanation of the Benefits, Limitations and Exclusions for each plan. If you need additional copies, please visit our City of Hope Intranet Site or contact your Human Resources Department.

Changing Your Benefits

Once your elections take effect, following Open Enrollment, you are not able to make changes until the next Open Enrollment Period. Certain exceptions may be allowed during the year for Qualifying Events, if submitted within 30 days of the event. Examples of some of the qualified changes in your status that allow you to change your benefits during the year include:

- Marriage, divorce or legal separation
- Death of your dependent child, spouse or domestic partner
- Change in your, your spouse's or domestic partner's employment status that results in loss or gain of coverage
- Birth, adoption or change in the custody of your child
- A change in your dependent's eligibility status due to marriage, age, graduation or loss of dependent status for federal tax purposes

Consult Benefit and Employee Services for other qualifying events

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 16 for more details.

Employee Self-Service

Benefits information and more can be found online on the City of Hope Intranet Site.

For first time users:

User ID is your Employee ID number

Password is your PeopleSoft password

Password: If you don't remember your PeopleSoft password, please click on *Forgot Your Password*. You will be prompted to answer qualifying questions and your password will be emailed to you.

Benefits and Employee Services

If you need further assistance, contact **Benefits and Employee Services** at 626-256-4673 ext. 62228. You can also email questions to benefits@coh.org.

Paying for Your Benefits Contributions and Flex Credits

The charts below show the *per pay period* contribution amounts for full-time employees. Part-time employees' costs are prorated based on scheduled hours. The contribution amount is based on *flex credits* that are given by City of Hope. You will see these amounts when you complete your annual online enrollment. All contributions shown reflect the cost to you after the flex credit has been applied.

On your paycheck, your pretax deductions plus your post tax deductions, minus your flex credits equal your total cost of benefits.

Kaiser- Medical HMO	
Employee Only	-\$4.50
Employee + Spouse	48.48
Employee + Child	45.94
Family	66.36

Delta Care- Dental DHMO	
Employee Only	-\$1.00
Employee + Spouse	4.66
Employee + Child	5.62
Family	10.19

Blue Cross- Medical HMO	
Employee Only	-\$2.25
Employee + Spouse	59.42
Employee + Child	48.61
Family	83.72

Met Life- Dental DPPO	
Employee Only	\$0.00
Employee + Spouse	17.07
Employee + Child	18.39
Family	36.74

Blue Cross- Medical PPO	
Employee Only	\$25.00
Employee + Spouse	96.28
Employee + Child	91.56
Family	128.76

VSP- Vision PPO	
Employee Only	\$7.75
Family	7.75

Based on your employee classification, Basic 1x Life/AD&D, Base 40% LTD, and STD are paid for by City of Hope.

MORE QUESTIONS?

Contact: COH Benefit and Employee Services
626-256-4673 ext 62228
Email: benefits@coh.org



Voluntary Benefits

The Standard- Life

Employee	\$0.051 per \$1,000 of coverage
Spouse	\$0.134 per \$1,000 of coverage
Children	\$0.092 per \$1,000 of coverage

The Standard- AD&D

Employee	\$0.009 per \$1,000 of coverage
Employee + Family	\$0.014 per \$1,000 of coverage

The Standard- Disability Buy-up

Supplemental LTD*	\$0.210 per \$100 of covered pay period covered earnings
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*City of Hope pays 100% of the basic LTD premium. Cost shown above is employee cost of the 60% voluntary LTD buy-up plan.

The City of Hope Benefit Program allows you to pay for benefits based on those you select. Here's how it works:

- Each benefit has a per pay period cost of providing that benefit to you.
- You are allotted Flex Credits to purchase the benefits that best meet your needs.
- Flex Credits are prorated for part-time employees.
- If you are a full-time employee, the pay period Flex Credits are listed in the chart below. If the benefits you select cost more than the flex credits provided, you will make up the difference through payroll deductions. If the benefits you select cost less than your allotment of flex credits, you receive the difference in each paycheck over the course of the year in the form of additional taxable earnings.

Flex Credits for Full-time Employees

Elect Medical & Dental	\$204.19
Elect Medical, Waive Dental	187.04
Elect Dental, Waive Medical	34.51
Waive Medical & Dental	17.36

Life and AD&D flex credits - Refer to Employee Benefit Class

Anthem Blue Cross/BC PPO Plan

Lifetime Maximum	\$5,000,000	
Deductible	<u>In-Network</u>	<u>Non-Network</u>
Individual Family Hospital	\$250 Maximum 3 separate deductibles \$500 per admission (non-network)	
Out-of-Pocket Maximum		
Individual excludes deductibles	\$1,500 per member	\$4,500 per member
Physician Services		
Office Visit	Copay: \$20	30%
Specialist Office Visit	Copay: \$20	30%
Preventive Care		
Routine Physical Exam	No Charge	30% (\$250 max. benefit)
Well Child/Immunizations	No Charge	30% (to max)
Routine GYN Visit	Copay: \$20	30%
Routine Mammograms	No Charge	30%
Hospitalization	10%	30%
Diagnostic Procedures		
Lab & X-ray	10%	30%
Emergency Services	10% + \$50/visit (waived if admitted)	
Outpatient Surgery Hospital	10%	30%
Mental Health Services / Alcohol/Substance Abuse	See Evidence of Coverage for detail of benefits	
Prescription Drugs: Formulary	Pharmacy (30 day supply)	
	Retail	
Generic	Copay: \$10	
Formulary Brand	Copay: \$30	
Non-Formulary Brand	Copay: \$45	
	Mail Order (90 Day supply)	
Generic	Copay: \$20	
Formulary Brand	Copay: \$60	
Non-Formulary Brand	Copay: \$90	

City of Hope Medical Group physicians only are available under the Anthem Blue Cross PPO plan.

MORE QUESTIONS?

Contact: Anthem Blue Cross Member Services
877-359-9655

Web site: www.anthem.com



Anthem Blue Cross HMO Plan

Lifetime Maximum	None
Deductible	None
Copay Maximum	
Individual	\$1,000
Family	\$2,000
Physician Services	
PCP Office Visit	Copay: \$20
Specialist Office Visit	Copay: \$20
Preventive Care	
Routine Physical Exam	Copay: \$20
Well Child/Immunizations	Copay: \$20
Routine GYN Services	Copay: \$20
Routine Mammograms	No Charge
Hospitalization	No Charge
Diagnostic Procedures	
Lab & X-ray	No Charge
Emergency Services	Copay: \$50/visit (Waived if admitted)
Outpatient Surgery Facility	No Charge
Mental Health Services / Alcohol /Substance Abuse	See Evidence of Coverage for detail of benefits
Prescription Drugs: Formulary	Pharmacy (30 Day supply)
Generic	Copay: \$10
Formulary Brand	Copay: \$30
Non-Formulary Brand	Copay: \$45
	Mail Order (90 Day supply)
Generic	Copay: \$20
Formulary Brand	Copay: \$60
Non-Formulary Brand	Copay: \$90

City of Hope Medical Group physicians are **not** available under the Anthem Blue Cross HMO plan.

MORE QUESTIONS?

Contact: Anthem Blue Cross Member Services

877-359-9655

Web site: www.anthem.com



Kaiser HMO Plan	
Lifetime Maximum	None
Deductible	None
Copay Maximum	Individual \$1,500 Family \$3,000
Physician Services	PCP Office Visit Copay: \$10 Specialist Office Visit Copay: \$10
Preventive Care	Routine Physical Exam Copay: \$10 Well Child/Immunizations Copay: \$5 (0-23 months) Routine GYN Services Copay: \$10 Routine Mammograms No Charge
Hospitalization	No Charge
Diagnostic Procedures	Lab & X-ray No Charge
Emergency Services	Copay: \$50 (waived if admitted)
Outpatient Surgery	Copay: \$10
Mental Health Services / Alcohol /Substance Abuse	See Evidence of Coverage for detail of benefits
Prescription Drugs: Formulary	Pharmacy (100 Day supply) Generic Copay: \$10 Brand Name Copay: \$20

City of Hope Medical Group physicians are not available under the Kaiser HMO plan.

MORE QUESTIONS?
 Contact: Kaiser Member Services
 800-464-4000
 Web site: www.kp.org



DeltaCare USA DHMO

Annual Maximum	None						
Annual Deductible	None						
Plan Year Maximums	See copayment schedule in your DeltaCare USA Plan Schedule.*						
Benefits	Copayments will vary based upon the type of service provided. Please refer to your DeltaCare USA Plan Schedule.*						
Ortho Services	<table style="width: 100%; border: none;"> <tr> <td style="width: 20%; padding-right: 10px;">Child</td> <td>Copay: \$1,700</td> </tr> <tr> <td>Adult</td> <td>Copay: \$1,900</td> </tr> <tr> <td></td> <td><small>Additional pre and post-orthodontic treatment visit copays may apply</small></td> </tr> </table>	Child	Copay: \$1,700	Adult	Copay: \$1,900		<small>Additional pre and post-orthodontic treatment visit copays may apply</small>
Child	Copay: \$1,700						
Adult	Copay: \$1,900						
	<small>Additional pre and post-orthodontic treatment visit copays may apply</small>						

*See the Benefits Intranet Site for copayment schedule.

MetLife DPPO

Plan Year Maximum	\$1,500 per person	
Annual Deductible	<u>DPPO In-Network</u>	<u>Non-Network</u>
	Individual Family	\$75 \$225
	<small>(Deductible waived for Diagnostic / Preventive)</small>	
Covered Services		
Diagnostic/Preventive	Covered: 100%	Covered: 80%
Basic	Covered: 50%	Covered: 40%
Periodontics/Endodontics	Covered: 50%	Covered: 40%
Major Services	Covered: 50%	Covered: 30%
Orthodontics	Covered: 50% \$1,500 lifetime max	Covered: 50% \$1,500 lifetime max

MORE QUESTIONS?

Contact: DeltaCare USA at 800-422-4234
 MetLife Member Services at 800-942-0854
 Website: www.deltadentalins.com
 Website: www.metlife.com



Standard Basic Life/AD&D - Non-Union only

New

<p>Amount of Life/AD&D Insurance</p> <p>Non-Union</p>	<p>1 x annual earnings to \$1,500,000 Maximum is combined with Voluntary Life amount</p>
<p>Guarantee Issue</p>	<p>\$750,000 combined with Voluntary Life amount amounts over guarantee issue are subject to proof of insurability</p>
<p>Portability</p>	<p>Feature available</p>
<p>Benefits reduce on/after 70th birthday. See Summary Plan Description for percentage reduction. This benefit is paid for by City of Hope.</p> <p>See page 12 for Voluntary Life Options.</p>	

Standard Life and AD&D - Union only

<p>Amount of Life Insurance</p> <p>Union</p>	<p>Choice of: \$5,000, \$50,000, \$60,000 (<i>new option</i>), or 1 to 6 x annual earnings to \$1,500,000</p>
<p>AD&D Amount</p> <p>Union (separate election from Life benefit)</p>	<p>Employee only or Family coverage Choice of: \$5,000, \$50,000, \$60,000 (<i>new option</i>), or 1 to 6 x annual earnings to \$1,500,000</p>
<p>Guarantee Issue</p>	<p>\$600,000 applies to Life insurance only amounts over guarantee issue are subject to proof of insurability</p>
<p>Portability</p>	<p>Feature available</p>
<p>Benefits reduce on/after 70th birthday. See Summary Plan Description for percentage reduction. Flex credits available for benefit.</p>	

MORE QUESTIONS?

Contact: Standard Claims Services
Life/AD&D: 800-628-8600
Web site: www.standard.com



Extended Illness Bank

Eligibility	Full-time; Prorated part-time; Newly hired
Benefit	In addition to normal sick time, EIB provides a second bank of hours. Any sick time not used at last day of calendar year will be credited to EIB.
Maximum Hours	480

Standard Short Term Disability

New

Weekly Benefit	60% weekly earnings to weekly maximum of \$2,192
Benefit Waiting Period	7 days illness 0 days accident (non-work related)
Maximum Benefit Period	Up to 180 days

Standard Long Term Disability

Monthly Benefit	40% of monthly earnings to \$9,500/month
Benefit Waiting Period	180 days
Maximum Benefit Period	To Age 65
Annuity Premium Benefit	Contributions to you retirement plan continue while on disability.
Coordination of Benefits	See your Summary Plan Description for coordination with other income sources.
Benefits reduce: Age 65 to 68 - pays to age 70; Age 69 or older - 1 year benefit See page 13 for Voluntary LTD Buy-up to 60%.	

MORE QUESTIONS?

Contact: Standard Claims Services
STD/LTD: 800-368-2859
Web site: www.standard.com



VSP Vision

	<u>VSP In-Network</u>	<u>Non-Network</u>
Eye Exam Once every 12 months	Covered in full	Up to \$45
Lenses (Single, Lined Bifocal & Trifocal) Once every 12 months	Covered in full	From \$45-\$125
Frame Once every 24 months	Covered up to \$120 Plus 20% off out-of-pocket costs	Up to \$47
Contacts Elective	(In lieu of lenses and frame) \$120 allowance	Up to \$105
Copay Exam & Materials Contacts	Copay: \$20 No copay applies	

Benefit Concepts Flexible Spending Accounts

FSA:Health Reimbursement	Allows up to \$5,000 per year for salary reduction and subsequent pre-tax reimbursement for qualified health related expenses not covered by your health plan.
FSA:Dependent Care Costs	Allows up to \$5,000 per year for salary reduction and subsequent pre-tax reimbursement for dependent care expenses.

Adoption Assistance

Allows up to \$12,150 per child per year for salary reduction and subsequent pre-tax reimbursement for adoption expenses.

MORE QUESTIONS?

VSP Member Services: 800-877-7195

Web site: www.vsp.com

Benefit Concepts FSA: 800-969-2009

Web site: www.avantserve.com



Standard Voluntary Term Life - Non-Union New	
Employee Coverage	1, 2, 3, 4 or 5 times annual earnings to \$1,500,000 Maximum is combined with Basic Life amount
Spouse/Domestic Partner Coverage	Choice of: \$5,000, \$10,000, \$25,000, \$50,000, \$100,000, \$150,000, or \$200,000 (not to exceed 100% of employee's Voluntary Life coverage)
Children Coverage	\$5,000 or \$10,000 (not to exceed 100% of employee's Basic Life coverage)
Portability	Feature available
Guaranteed Issue	Employee: \$750,000 combined with Basic Life amount. Employees that have previously waived the Life benefit will have a Guaranteed Issue of \$50,000. Spouse: \$50,000
Amounts over the Guaranteed Issue will be subject to Evidence of Insurability. Waiver of premium is included.	

Standard Voluntary AD&D - Non-Union only New	
Employee Coverage	1, 2, 3, 4 or 5 times annual salary to \$1,500,000 Maximum is combined with Basic AD&D amount.
Family Coverage	1, 2, 3, 4 or 5 times annual salary to \$1,500,000 Maximum is combined with Basic AD&D amount.
Portability	Benefit will not be continued upon termination of employment

MORE QUESTIONS?

Contact: Standard Claims Services
Life/AD&D: 800-628-8600
Web site: www.standard.com



Standard Long Term Disability Buy-up

Monthly Benefit	60% of monthly earnings to \$9,500/month
Benefit Waiting Period	180 days
Maximum Benefit Period	To Age 65
Annuity Premium Benefit	Contributions to your retirement plan continue while on disability.
Coordination of Benefits	See your Summary Plan Description for coordination with other income sources.
Benefits reduce: Age 65 to 68 - pays to age 70; Age 69 or older - 1 year benefit	

MetLaw - Hyatt Legal Plans

You may purchase legal services through MetLife at a discount. If you enroll in this plan, your monthly premiums will cover the total cost for most services under the plan. The MetLife Legal Services Plan offers a variety of services through network attorneys. Here are just a few:

- Unlimited telephone advice and office consultation on most legal matters
- Preparation of wills, living trusts, powers of attorney, affidavits, deed and demand letters
- Document review & preparation
- Immigration assistance
- Portable
- Debt collection defense
- Real estate matters
- Court appearances

MetLife Home/Automobile Insurance

You may apply to purchase automobile, home and other property and liability insurance through MetLife.

Special group rates on insurance and personalized customer service.

- Special group rates
- Convenient payment options

MORE QUESTIONS?

Contact: MetLife Member Services

MetLaw: 800-821-6400

Home/Auto: 800-438-6388

Web site: www.metlife.com



VPI Pet Insurance

Deductible	\$50 per incident
Lost and Found Registration	\$12
Annual Maximum	\$9,000/year Standard Plan \$14,000/year Superior Plan
Optional Vaccination And Routine Care	\$144/year

AFLAC Voluntary Cancer Insurance

Benefits	Deductibles, copayments, child care, lost wages and travel costs
Continuation at Termination	Coverage is portable and will automatically be direct billed to home address upon termination of employment.

AFLAC Hospital Protection

If you or someone in your family needs to stay in a hospital, your medial plan may not cover 100% of the cost. The cost of these stays can add up quickly and Hospital Protection through AFLAC can help cover the extra expenses. This plan pays cash benefits directly to you to help cover these expenses.

AFLAC Personal Recovery Plus

Personal Recovery Plus through AFLAC provides a cash benefit if you have a major medical event such as a stroke, heart attack or coma. It also provides an additional benefit if you need continuing treatment such as dialysis, hospice care or physical therapy.

MORE QUESTIONS?
 Contact: Your Voluntary Benefit Consultants
 Josepha Arietta
 Juanita Miranda
 800-451-8037



Horizon Employee Assistance Program

New

A master's level Member Advocate from Horizon Health EAP Services will confidentially consult with you over the phone and help you find solutions and resources to meet life's challenges. The Member Advocate will provide you with consultation, resources, an action plan and information to help you address your issue. You may also receive referrals to support groups, community resources, a Horizon network counselor or your health plan.

HorizonCare services can help with the following issues, among others:

- Childcare and eldercare
- Alcohol and drug abuse
- Difficulties in relationships
- Stress and anxiety with work or family
- Depression
- Grief and loss
- Identity theft and fraud resolutions

**Convenient and confidential.
Available 24 hours a day, 7 days a week.**

1-800-342-8111

www.HorizonCareLink.com

Login: city of hope

Password: eap

MORE QUESTIONS?

Contact: Horizon Health EAP

800-342-8111

Web site: www.horizoncarelink.com



Important Notice from City of Hope About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with City of Hope and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. For more Information about where you can get help to make decisions about your prescription drug coverage, please request an official "Creditable Coverage notice". If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty). Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Blue Cross and Kaiser Permanente have determined that the prescription drug coverage offered to City of Hope is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. *In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.* You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

GENERAL NOTICE OF
CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you recently became covered under City of Hope Group Health Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Under a Federal law known as the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), covered employees and covered family members must be given the opportunity for a temporary extension of health coverage (called “Continuation Coverage”) at group rates in certain instances where coverage under the plan would otherwise end due to certain qualifying events. This notice gives only a summary of your COBRA continuation coverage rights. For more complete information about your rights and obligations under the Plan and under Federal law, you should either review the Plan’s Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Qualified beneficiaries are those individuals, i.e. employee, spouse, dependent child, who are covered under the Plan on the day before a qualifying event. A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage is also eligible to become a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

Qualifying Events for Covered Employee - If you are an employee and you are covered by the Plan(s), you have a right to choose COBRA Continuation Coverage if you lose your group health coverage because of a reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct on your part).

Qualifying Events for Covered Spouse -If you are the spouse of an employee covered by the Plan(s) you have a right to choose Continuation Coverage if group health coverage under the Plan(s) is lost for any of the following four (4) reasons:

The death of your spouse;

A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment

Divorce or legal separation from your spouse; or

Your spouse becomes enrolled in Medicare (Part A, Part B or both).

Qualifying Events for Covered Dependent Children - In the case of a dependent

child of an employee covered by the Plan(s), he or she has the right to choose Continuation Coverage if group health coverage under the Plan(s) is lost for any of the following five (5) reasons:

The death of the parent-employee

A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment

Parent's divorce or legal separation;

The parent-employee becomes enrolled in Medicare (Part A, Part B or both); or

The dependent child stops being eligible for coverage as a "*dependent child*" under the Plan(s).

Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding under title 11 of the United States Code and these individuals lose coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. If the qualifying event is a termination of employment or a reduction in hours, the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both), or in the case of certain retirees, commencement of a bankruptcy proceeding under title 11 of the United States Code, the employer must notify the Plan Administrator of the qualifying event.

If the qualifying event is a divorce, legal separation, or a child losing dependent status under the Plan(s) you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send the notice to City of Hope Benefits and Employee Services, 1500 East Duarte Road, Durate, CA 91010. You must also provide additional documentation such as a copy of the divorce decree or proof that a child is no longer a "dependent" under the Plan(s). If you do not notify the Plan Administrator within the 60 days of the second event, you will not qualify for the extension.

When the Plan Administrator is notified that a qualifying event has occurred, the Plan Administrator will in turn notify qualified beneficiaries of their rights to elect COBRA continuation coverage. Each qualified beneficiary has the right to make his or her own election.

Covered employees may elect coverage on behalf of their spouses and parents may elect coverage on behalf of their children. The maximum period allowed to elect COBRA is 60 days from the later of (1) the date coverage is lost under the Plan(s) or (2) the date they are notified of their right to elect Continuation Coverage to make their election. The Plan(s) does not provide an extension of the election period beyond what is required by law. **If a qualified beneficiary does not elect Continuation Coverage within this election period, then rights to continue health insurance end.**

If you choose Continuation Coverage you must be given coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan(s) to similarly situated employees or family members. The law requires that

you be given the opportunity to elect COBRA continuation coverage for 36 months if you lose coverage as a result of the covered employee's death, divorce, legal separation, the covered employee's enrollment in Medicare (Part A, Part B or both) or a dependent child's losing eligibility as a dependent child under the health Plan.

If the qualifying event is a termination of employment or a reduction in the employee's hours of employment, COBRA continuation coverage will last for 18 months. There are two ways in which the 18-month period may be extended:

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time before or during the first 60 days of COBRA coverage and the Plan Administrator is notified of the Social Security's determination within 60 days of the later of (1) the date of the Social Security's determination, (2) the date on which the qualifying event occurs, or (3) the date on which you lose coverage under the Plan as a result of a qualifying event, you and your family can receive up to an additional 11 months of COBRA continuation coverage. The Plan Administrator must receive the notification before the end of the 18-month period. If you apply to the Social Security Administration for disability benefits, they will notify you in writing of the determination. The written notification from the Social Security Administration must be sent to City of Hope Benefits and Employee Services 1500 East Duarte Road, Durate, CA 91010, if you are an active employee. If you are receiving COBRA administration coverage, you must send it to the COBRA administrator.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event that results in a loss of coverage while receiving COBRA continuation coverage, the spouse and dependent children, if any, in your family may receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This

extension is available to the spouse and dependent children if coverage is lost as a result of the former employee's death, enrollment in Medicare (Part A, Part B or both), divorce or legal separation. It is also available to a dependent child when that child stops being eligible under

the Plan as a dependent child and loses coverage. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. **If you do not notify the Plan Administrator within the 60 days of the second event, you will not qualify for this extension.**

If a covered employee enrolls in Medicare and then terminates employment or has a reduction in hours and loses coverage, COBRA continuation coverage for qualified beneficiaries other than the covered employee lasts for 36 months and begins on the date the covered employee enrolled in Medicare.

Example: A covered employee enrolls in Medicare 8 months before his employment terminates. His spouse and child are entitled to another 28 months of coverage after his termination of employment for a total of 36 months of continuation coverage.

The law also provides that COBRA continuation coverage may end for any of the following reasons:

Your employer no longer provides group health coverage to any of its employees;

The premium for continuation coverage is not paid on time;

A qualified beneficiary becomes covered under another group health plan, after the date of the qualified beneficiary's COBRA election, that does not contain any exclusion or limitation with respect to any pre-existing conditions such qualified beneficiary may have;

A qualified beneficiary becomes enrolled in Medicare (Part A, Part B or both), after the date of the qualified beneficiary's COBRA election;

A qualified beneficiary extends coverage for up to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled.

If you are eligible for coverage under the health flexible spending account, that coverage will continue only for the remainder of the Plan Year in which your qualifying event occurred.

You do not have to show that you are insurable to choose Continuation Coverage. However, Continuation Coverage under COBRA is provided subject to your eligibility for coverage. If you are determined ineligible for COBRA coverage, your Employer reserves the right to terminate it retroactively.

Under the law, you may have to pay all or part of the premium for your Continuation Coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. *The law also says that, at the end of the 18 month, 29 month or 36 month Continuation Coverage period, you must be allowed to enroll in an individual conversion health plan if it is provided under the Plan(s).*

If You Have Questions

If you have any questions about the Plan or COBRA law or need to provide notification of a divorce, legal separation or a child losing dependent status, please contact City of Hope Benefits and Employee Services 1500 East Duarte Road, Durate, CA 91010, 626-256-4673 ext. 62228. For more information about your rights under ERISA, including COBRA, and the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of Regional and District EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of addresses of participants or beneficiaries who are or may become qualified beneficiaries. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The Newborn’s and Mother’s Health Protection Act of 1996

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.



Women’s Health and Cancer Rights Act of 1998

The federal Women’s Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

1. Reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction on the other breast to produce a symmetrical appearance;
3. Prostheses;
4. Treatment of physical complications of all states of mastectomy, including lymphademas.



Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of “medically necessary.” Benefits will be provided on the same basis as for any other illness or injury under your plan. Coverage is subject to applicable deductibles, copayments and coinsurance payments.

Mental Health Parity Act

When required by law, it is the intent of this Plan that health care benefit plans comply with the federal Mental Health Parity Act (MHPA). In general, the law requires parity of mental health benefits, meaning that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical

benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. In addition, the law provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity). The law does not apply to benefits for substance abuse or chemical dependency.

The law also contains the following two exemptions, the small employer exemption and the increased cost exemption. The Small Employer Exemption restricts the MHPA from applying to any group health plan or coverage of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year, and who employs at least 2 employees on the first day of the plan year. The Increased Cost Exemption restricts the MHPA from applying to any group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least one percent. If the Increased Cost Exemption is invoked, the employer must disclose this information.

Qualified Medical Child Support Orders

A dependent Child may become eligible for coverage by way of a QMCSO. If approved, coverage will become effective as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process. The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient
(or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

A Plan participant must submit a Medical Child Support Order to the Plan Administrator to determine whether it is qualified, and thus a QMCSO. A copy of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders may be requested from Plan Administrator, at no charge.





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