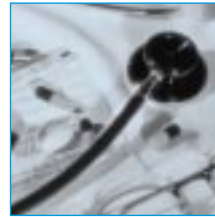
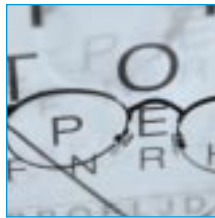




The Consolidated Edison Retiree Health Program



Understanding Your Health Care Benefits

A SUMMARY PLAN DESCRIPTION



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The Retiree Health Program

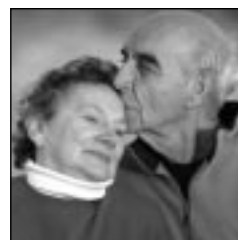
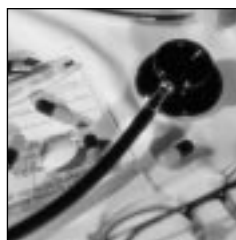
This booklet describes the health care benefits that are available to eligible retirees of Consolidated Edison Company of New York, Inc. (CECONY) and their eligible dependents under the *Consolidated Edison Retiree Health Program* as of July 2003. In addition, certain affiliates of Consolidated Edison, Inc. (CEI) have adopted the Program for some of their eligible retirees (CEI Affiliates). Throughout this booklet, CECONY and each CEI Affiliate that have adopted the *Retiree Health Program* are referred to as an Employer. The company is CECONY.

The Retiree Health Program includes the following:

- The **Retiree Health Plan** – If you are age 65 or older and *eligible for Medicare* (or a qualified disabled employee), the Plan coordinates benefits with Medicare and is administered by United HealthCare Service, LLC (UnitedHealthcare). If you are under age 65 and *non-Medicare-eligible*, you can use the UnitedHealthcare **Preferred Provider Organization (PPO)**. The **Retiree Health Plan** provides hospital, medical, and vision benefits.
- A **Prescription Drug Plan** administered by Caremark Inc.
- A **Health Maintenance Organization (HMO)** if you are under or over age 65.

Once you're enrolled, you can change your health care selection during each open enrollment period.

This booklet is the summary plan description (SPD) of the *Retiree Health Program*, as required under the Employee Retirement Income Security Act of 1974, as amended (ERISA). It replaces the *Retiree Health Program* SPD booklet dated July 1997, and supplements to that booklet.



If you are a retiree of **CECONY** or a **CEI Affiliate**, you can speak with an Employee Benefits representative at Con Edison by calling 1-800-582-5056. Benefits representatives are available from 9:00 a.m. to 4:00 p.m., EST, Monday through Friday (except holidays).

Although the company currently sponsors the *Retiree Health Program*, neither the company nor any Employer has an obligation to any employee, retiree or other participant to continue the Program for any fixed period of time or throughout the duration of a participant's lifetime. The company reserves the right to change, amend, modify or terminate the Program, in whole or in part, at any time. Each Employer has the right to end participation in the *Retiree Health Program* on behalf of its participating retirees.

Participating retirees, surviving spouses and all other participants in the Program are responsible for the full cost of the *Retiree Health Program* except to the extent that the company and the Employer's elect to pay a part of the cost. Although your Employer may elect to pay part of the cost in future years, neither the company nor any Employer is committed to contribute any fixed amount or percentage of Program costs.

Beginning in January 2008, the company and the Employers' contribution, if any, will be the maximum amount of the previous year's contribution, plus a cost of living adjustment. The cost of living adjustment may be up to the change in the Consumer Price Index (CPI). If Program costs are projected to increase above the cost of living adjustment, your Employers' contribution will not be enough to cover the rise in costs, and your monthly contribution will increase.

If you have downloaded this SPD electronically, you have the right to request and receive a paper copy by contacting Employee Benefits at 1-800-582-5056. If you would like to download this SPD electronically, visit the Con Edison **Retiree web site** at <http://retirees.coned.com>. You may contact Employee Benefits and provide them with your current e-mail address for updates to this material.

*The information included in this summary plan description describes the **Retiree Health Program** as of July 2003. However, the **Retiree Health Program** is subject to change from time to time and material changes will be reported and made available to you as changes are made.*



Retiree Health Program Highlights

Before you decide whether to join the **Retiree Health Plan**, the **Prescription Drug Plan**, or an **HMO**, it's important to understand the provisions of each option so you can make the selection that best meets your health care needs.

The **Retiree Health Plan** offers hospital, medical and vision care benefits. The **Retiree Health Plan** does not provide or offer dental services. Beginning February 1, 2003, the **Retiree Health Plan** is administered by United HealthCare Service, LLC, referred to as UnitedHealthcare throughout this booklet.

The **Prescription Drug Plan** provides mail-order, and retail prescription drugs and medicines.

The **HMOs** are an alternative to the **Retiree Health Plan**, offering hospital, medical, some preventive dental and preventive care services, and vision care benefits. Your prescription benefits are covered by your **HMO**. More details about **HMOs** are described in this booklet.

Effective 2003, the following chart¹ summarizes the major benefits available under the **Retiree Health Plan** and **HMOs** (rates are subject to change each year).

	Benefits	Retiree Health Plan	HMOs
<i>Hospital</i>	Semi-private room and board	Covered in full	Covered in full
	Annual deductible	50% of Medicare Part A deductible	None
	Emergency room	Covered in full for accidental injury and for serious illness	Charges vary from \$0 to \$75 per visit
	Hospice Care	365 days/lifetime (inpatient/outpatient)	Varies from 210 days unless recertified
<i>Medical</i>	Physician Services		
	- Network office Visit co-pay	\$ 18	Charges vary from \$0 to \$25 per visit
	- Annual deductible	\$ 500	
	Preventive Care		
	- Annual physical	One well woman exam per year including Ob/Gyn exam and pap smear	Charges vary from \$0 to \$10 per visit
	- Mammography	Covered in full; at 100% of R&C	Charges vary from \$0 to \$10
- Cytology screening	Covered in full after deductible; at 80% of R&C	Charges vary from \$0 to \$10	
	Ambulance	After deductible, you pay 20%	None in most cases
<i>Vision Care</i>		1 routine eye exam/1 pair eyeglasses every 24 months	Routine eye exams; charges vary from \$5 to \$20; eyeglasses every two years may be covered in full or covered to maximum payment
<i>Prescription Drug</i>	Annual deductible	\$ 100	None
	Your co-payment	\$ 10 generic \$ 18 name-brand	Varies from \$0 to \$10 generic \$0 to \$15 name-brand
	Mail-order (for up to 90-day supply)	\$ 8 generic \$ 14 name-brand	Varies from \$0 to \$40 for a 30 or 90-day supply; or not covered

¹ This chart is a very broad overview of Plan highlights. Please keep in mind that provisions are different for the type of services, whether you are Medicare-eligible, or non-Medicare-eligible, and whether you are using a network or non-network provider. For more accurate Plan information, please read the appropriate section in this booklet or speak to your health care provider.

HMO Information – Benefit Plan Differences

While the **Retiree Health Plan** and the **HMOs** offer similar benefits, there are differences in how these plans operate. Unlike the **Retiree Health Plan**:

- the **HMOs** do not require a deductible or coinsurance,
- some **HMO** services do not require co-payments or out-of-pocket payments,
- **HMOs** offer preventive services at little or no cost,
- some **HMOs** offer preventive dental services,
- **HMO** participants do not have to file claim forms, *and*
- your choice of doctors is restricted when you join an **HMO**.

The **HMOs**² provided under the *Retiree Health Program* all offer similar benefits. However, when a co-payment is required, each **HMO** has a somewhat different co-payment and a different level of coverage. To obtain more information about **HMOs**, it's important to contact the **HMO** directly to request material listing specific benefits and policies.

Upon request, the **HMO** will send you written materials that describe the services it provides to participants. This description includes eligibility rules, circumstances under which benefits may be denied and the procedures to follow to obtain benefits and a review of any denial of benefits.

² Please note that under the Medicare guidelines, not all **HMOs** are available to retirees. Check with the **HMO** for more information.



Eligibility Rules And Requirements

Who is Eligible

CECONY Retiree: You are eligible to participate in the *Retiree Health Program* if on the day you end your employment with CECONY you:

- are actively employed,
- are covered under the health plan for active employees or another group health plan,
- are a participant in the *Consolidated Edison Retirement Plan* (Retirement Plan), *and*
- have at least 75 Points, as that term is defined and explained in the Retirement Plan, on the day of or before you terminate employment (Rule of 75 Pension).

If you terminate employment from CECONY as a result of a total and permanent disability (as determined at the discretion of the Plan Administrator) on or after you reach age 50, you have at least 20 years of accredited service, and you are a participant in the Retirement Plan (Disability Pension), you are eligible to participate in the *Retiree Health Program* even though you do not have 75 Points.

CECONY Transfer Employee: If you are a former employee of CECONY without a break in employment and you directly transfer employment to a CEI Affiliate, you may be eligible to participate in the *Retiree Health Program*. You must satisfy the same requirements and conditions as a CECONY retiree.

Non-union employees who worked at the Western Massachusetts Electric Company on or before July 18, 1999 (acquisition date by CEEM), and continuing after January 1, 2000, may be eligible to participate in the Program. Call Employee Benefits for more details.

A CEI Affiliate includes the wholly owned subsidiaries formed or acquired by CEI, including: Orange and Rockland Utilities, Inc., Consolidated Edison Communications, Consolidated Edison Development, Consolidated Edison Energy, Consolidated Edison Solutions, CED Operating Company, LP, and Consolidated Edison Energy Massachusetts.



Eligibility Date: If upon leaving the employment of the company, you satisfy the eligibility requirements, you must elect to participate on your eligibility date. In most instances, your eligibility date is within the 31-day period following the first day you satisfy the eligibility requirements (generally the day you leave the employment of the company) and are eligible to elect to receive an immediate distribution of your Rule of 75 Pension.

If you do not elect to participate on your eligibility date, you will no longer be eligible to participate. It is your responsibility to notify your Employer when you are first eligible to participate.

You may defer your participation in either the **Retiree Health Plan** or **Prescription Drug Plan** if you are covered by another group health plan or prescription drug plan (as an employee or dependent) on your eligibility date. If you defer your participation, you must then provide satisfactory proof of continuous coverage in the other health plan or prescription drug plan before you can participate in the *Retiree Health Program*.

Eligible Dependents

The *Retiree Health Program* is available to an eligible spouse, domestic partner, surviving spouse or dependent child of a retiree receiving a CECONY Pension or as long as the following requirements are met:

- The spouse/domestic partner is not an active employee of an Employer and covered under the active employee health plan. If your spouse or domestic partner is covered under the active employee plan, he or she may not be covered under the *Retiree Health Program*.
- A spouse may not always be considered a surviving spouse. Only a surviving spouse may continue participation in the *Retiree Health Program* after the retiree's death. A spouse is a surviving spouse if he or she is receiving a surviving spouse's pension benefit from the Retirement Plan and is legally married to the retiree on the date of his or her death. A surviving spouse must either already be covered by the *Retiree Health Program* or have other coverage. **A domestic partner is not considered a surviving spouse.**
- If the retiree marries, remarries, or forms a domestic partnership after his or her pension allowance begins, that spouse or domestic partner is eligible to participate. However, that spouse or domestic partner is not eligible to receive surviving spouse benefits or to continue his or her participation in the *Retiree Health Program* when the retiree dies.
- During the lifetime of a retiree or surviving spouse, unmarried dependent children are eligible until the end of the calendar year in which the child reaches age 19, or if he or she is a full-time student, until the end of the month in which the child reaches age 23. If your child is a full-time student, proof of full-time student status at an accredited secondary school is required.
- When a retiree dies, the retiree's surviving dependent children continue to be eligible for coverage only if the retiree's surviving spouse is receiving a pension benefit from the Retirement Plan. If you are a retiree without a surviving spouse on the date of your death, your dependent child will not be eligible to continue participation.
- After becoming a participant, if a retiree marries or acquires an eligible dependent child, the new spouse and dependent child are eligible for coverage only as long as the retiree remains a covered participant. They are not eligible after the death of the retiree.
- An eligible dependent child includes a legally adopted child, a child placed in your household in anticipation of being legally adopted, a stepchild of a retiree or surviving spouse, or a child living with a retiree or surviving spouse if the retiree or surviving spouse is the child's legal guardian.

The company requires proof of a child's dependent status before approving coverage. A dependent child must not be regularly employed on a full-time basis and must be fully dependent on the retiree or surviving spouse for support.

- A domestic partner must be registered with CECONY and must be a same sex partner.
- If a surviving spouse re-marries, his or her spouse is not eligible to participate. Also, if a surviving spouse acquires a dependent child who was not the eligible dependent child of the retiree, the child is not eligible to participate.
- A retiree's or surviving spouse's covered unmarried disabled dependent child is eligible regardless of age, if the child becomes physically or mentally incapable of self-support either before age 19 or while he or she is a participant in the *Retiree Health Program*. To continue coverage for a disabled child after the date when coverage would end (at age 19 or 23), you must apply to UnitedHealthcare within 90 days before coverage would end. UnitedHealthcare has the sole and absolute discretion to determine disability status. Additional proof will be required from time to time as required by UnitedHealthcare. A disabled child's participation ends (regardless of age) on the date of death of the last living retiree or surviving spouse.
- In some cases a spouse/domestic partner or dependent child may be eligible for COBRA coverage.

When Your Spouse / Domestic Partner is a Con Edison Employee

When you retire, if you are married or in a domestic partnership with an active employee of CECONY or a CEI Affiliate, you may be covered as a dependent under your spouse/ domestic partner's active health plan until he or she leaves the company or retires. You and/or your spouse/domestic partner cannot be covered under both the *Retiree Health Program* and the active plan. If you are covered under the active plan, your eligibility date is the first day of the month immediately following the last day of the month that you are covered under the active plan of CECONY or a CEI Affiliate.



If your spouse/domestic partner satisfies the retiree requirements, you and your spouse/domestic partner are eligible to enroll in the *Retiree Health Program*. However, if your spouse/domestic partner retires or leaves before becoming eligible to receive a Rule of 75 Pension, you may enroll in the *Retiree Health Program* as a retiree with your spouse/domestic partner as your dependent.



How To Enroll

You can enroll in the *Retiree Health Program* by completing an Enrollment Form. To become a participant, you must enroll within the 31-day period immediately following your eligibility date. **If you don't enroll within the 31-day period of your eligibility date or decline participation, you, your spouse or domestic partner and dependent children are not eligible to participate in the Program at a later date.**

31-Day Rule Exception

If you are an eligible retiree, and you or your spouse/domestic partner is covered under another employer's group health plan (not an individual policy), after you leave the employment of the company, then you and/or your spouse/domestic partner may delay enrollment in the *Retiree Health Program*.

However, you must enroll on the first of the month immediately following the last day of your other group health plan coverage. Other coverage does not include Medicare, Medicaid or COBRA continuation coverage from the Con Edison health plan for active employees. You and your spouse/domestic partner must maintain coverage, without interruption under your other group plan, from the date you first become eligible for coverage under the *Retiree Health Program* until the date you wish to participate in the *Retiree Health Program*.

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



Pre-existing Conditions

Retirees and their dependents may enroll in the **Retiree Health Plan** even if they have pre-existing health conditions that might make them ineligible for other health plans. Enrollment in a **HMO** is open regardless of pre-existing health conditions to retirees and their eligible dependents. However, if you are Medicare-eligible and have end-stage renal disease or participate in a hospice program you may not enroll in a **HMO**.

Making Your Health Care Selection

At the time you complete your Enrollment Form, you can select either *individual* or *family coverage* under the **Retiree Health Plan**, **Prescription Drug Plan** or under any **HMO**.

If you choose a **HMO**, Employee Benefits will contact the **HMO** you select. The **HMO** will send you material that describes its benefits and policies.

If you're Medicare-eligible, you'll also receive a separate **HMO** Enrollment Form. You must complete the **HMO** Enrollment Form and return it to the **HMO** to complete your enrollment.

When Coverage Starts

You are covered under the *Retiree Health Program* on the first day of the month you become an eligible retiree and return to the company a completed Enrollment Form. Your eligible dependents will be covered if you enroll them. The *Retiree Health Program* Enrollment Form authorizes your Employer to deduct the required plan contributions from your monthly pension benefit. Coverage under the active health plan does not automatically transfer to the *Retiree Health Program*. If you are deferring your Rule of 75 Pension, but have enrolled in the *Retiree Health Program*, payments are made quarterly at the beginning of the quarter by sending a check to Employee Benefits.

Retiree Health Plan

The **Retiree Health Plan** provides hospital, medical and vision care services and supplies. UnitedHealthcare currently administers and processes all claims for the hospital, medical and vision care benefits. The **Retiree Health Plan** is a self-insured Program.

The **Retiree Health Plan** only pays for claims for accidental injury, sickness, or pregnancies, and in some cases, preventive care, up to a lifetime maximum of \$1 million for each covered person. Expenses incurred for hospital, medical and vision care are included in the lifetime maximum.

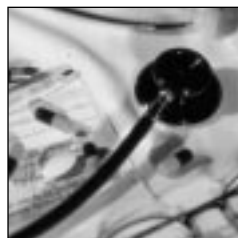
Final decisions about medical care are the responsibility of you and your doctor. If your doctor recommends care not covered under the Plan it is up to you to decide whether you should receive that care; however, you will be responsible for all non-covered expenses.

If you're Medicare-eligible, the **Retiree Health Plan** coordinates benefits with Medicare and offsets Medicare-approved charges from your reimbursement.

If you're non-Medicare eligible, you can take full advantage of medical providers in UnitedHealthcare's PPO network. Most network medical services will require a co-payment but you are not subject to the annual medical deductible.

You can also use providers who aren't in the network (called non-network providers). If medical services are given by a non-network provider, you are subject to an annual medical deductible. The **Retiree Health Plan** will pay 80% of the reasonable and customary charges and you will be responsible for all remaining costs.

You may also enroll in the **Prescription Drug Plan** under the Program. The **Prescription Drug Plan** is self-insured and administered by Caremark Inc.



Health Care Definitions

The following definitions will help you understand the **Retiree Health Plan**.

Ambulatory surgical center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures.

This type of facility is licensed as an ambulatory surgical center by the appropriate state agency it qualifies under or, if the facility is located in a state with no licensing requirements, it may qualify under the standards set by UnitedHealthcare. Where licensing is not required, these requirements, while not conclusive, may serve to treat the center as an ambulatory surgical center:

- It is operated under the supervision of a physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a qualified physician who is privileged to perform the procedure in at least one hospital in the area.
- It requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist who is administering the anesthetic and that the anesthesiologist or anesthesiologist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.
- It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
- It provides the full time services of one or more registered graduate nurses for patient care in the operating rooms and in the post-anesthesia recovery room.
- It maintains an adequate medical record for each patient.

To find out whether a particular facility qualifies, call UnitedHealthcare at 1-800-638-5199 or visit <http://www.provider.uhc.com>.

Coinsurance: Your share of the cost for reasonable and customary charges.

Co-payment: The amount a person must pay to a network provider at the time services are given. Co-payments are not counted toward any deductible or out-of-pocket limits. Covered health services that require a co-payment are not subject to a deductible.

Covered health services: Health services, supplies and treatments provided for the purpose of preventing, diagnosing or treating an accidental injury, sickness, mental illness, drug abuse or their symptoms. A covered health service is one which is not specifically excluded, experimental, unproven or investigational. Covered health services are included only when the person receiving the service meets all eligibility requirements including, if necessary, notification requirements.

Custodial care: Health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing. Custodial care is made up of services and supplies that are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment. Custodial care is care that can safely and adequately be provided by anyone who does not have the technical skills of a covered health care professional. Care is custodial care regardless of who recommends, provides or directs the care, where the care is provided, or whether the patient or another caregiver can be or is being trained to care for himself or herself.

Deductible: The amount for covered health services a person must pay before benefits are payable. After the applicable deductible has been met, covered health services are payable at the percentage shown in the *Schedule of Contributions and Co-Payments*.

Doctor: A licensed practitioner of the healing arts, acting within the scope of his or her license. The term doctor includes: dental surgeons, doctors of medical dentistry, osteopaths, chiropractors, podiatrists, licensed psychologists and Christian Science practitioners listed in the Christian Science Journal. The term doctor and physician have the same meaning.

Durable medical equipment: Equipment that meets all of the following criteria:

- ordered or provided by a physician for outpatient use,
- not a consumable or disposable item,
- used primarily for a medical purpose, *and*
- not used in the absence of a disease or disability.

Some examples of durable medical equipment are a standard hospital-type bed, a standard wheelchair, the rental of equipment to administer oxygen and oxygen concentrator units, delivery pumps for tube feeding, and braces that stabilize an injured body part including adjustments to shoes to accommodate braces. If more than one piece of durable medical equipment can meet your functional needs, then benefits are only available for the most cost-effective piece of equipment.



Fiduciary: The person or organization which has the discretionary authority and responsibility to make decisions and determinations regarding the operation and administration of the Program.

Hospice: An agency or hospital that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. An agency must meet one of the following three tests:

- it is approved by Medicare as a hospice, *or*
- it is licensed in accordance with applicable state laws, *or*
- it is a system of care given primarily in your home by a hospice team consisting of a doctor, a registered nurse, and possibly others, such as a licensed psychologist, a licensed social worker, a physiotherapist and an occupational therapist.

Hospice care program: A program directed by a doctor to provide supportive care to a terminally ill person – a person whose life expectancy is six months or less – and supportive care to their families. The program and facilities must meet the standards set by the National Hospice Organization and any applicable state standards.

Hospital: A hospital is a legally operated institution that:

- is accredited under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Healthcare Organizations,
- maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians, and continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered graduate nurses and is operated continuously with organized facilities for operative surgery on the premises, *or*
- is a Christian Science sanatorium accredited by the Department of Care of the First Church of Christ Scientist, Boston, Massachusetts. The sanatorium is considered a hospital if the patient is admitted for healing (not rest or study) and is under the care of a Christian Science practitioner.

A hospital is not primarily a place of rest for the aged, mentally infirm or for drug abuse. A nursing home is not considered a hospital.



Inpatient stays: Admission in a hospital, skilled nursing facility, hospice, alcohol or drug abuse treatment center, or rehabilitative facility.

L.P.N.: A licensed practical nurse.

Medicare approved charge: The claim amount Medicare decides is reasonable and customary. Medicare pays 80% of the approved charge after you meet your annual deductible.

Medicare-eligible: Medicare is a federal health insurance program for retirees age 65 and older and individuals who qualify under the Medicare disability rules. If you or your spouse is eligible for Medicare, you must enroll in Medicare Parts A and B as your primary coverage.

Network provider: A doctor or other health care provider who contracted with UnitedHealthcare to participate in the network.

Non-Medicare-eligible: A participant who is under age 65 and does not qualify for Medicare benefits.

Private-duty nursing: Consists of skilled services performed by an Registered Nurse (R.N.) or a L.P.N. who is not providing these services as an employee of a hospital or other health care institution or as a member of a home health care team.

Reasonable and customary charges: The **Retiree Health Plan** covers reasonable and customary charges for covered health services. Reasonable and customary charges for covered health services for Medicare-eligible participant's are the Medicare approved charges. When you use a network provider, reasonable and customary charges for non-Medicare-eligible participants are UnitedHealthcare's contracted rate. When you use a non-network provider, reasonable and customary charges for non-Medicare-eligible participants are the amount determined by UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare uses one or more of the following methods for evaluation and validation of all provider billings:

- as indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the American Medical Association,
- as reported by generally recognized professionals or publications,
- as determined by medical staff and outside medical consultants in agreement with other appropriate sources or determinations that UnitedHealthcare accepts.

R.N.: A registered nurse.

Skilled Nursing Facility: A skilled nursing facility is one approved by Medicare. If Medicare does not approve the skilled nursing facility, the facility may be covered if it:

- is operated under applicable licensing laws,
- is under the supervision of a licensed physician or registered graduate nurse who is devoting full time to supervision,
- is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness,
- maintains a daily medical record of each patient who is under the care of a licensed physician,
- is authorized to administer medication to patients on the order of a licensed physician, *and*
- is not, other than incidentally, a home for the aged, the hearing or seeing impaired, a hotel, a domiciliary care home, a maternity home, or a home for persons suffering from drug abuse or mental illness.

Subrogation: The right of the *Retiree Health Program* to pursue the participant's claims for medical or other charges paid by the Program against another person, the person's insurer and/or any other third party.





Hospital and Other Inpatient Care Benefits

The **Retiree Health Plan** pays for up to 365 days of reasonable and customary charges for semi-private room and board and care in a hospital and/or skilled nursing facility. The 365 days are on a per person per diagnosis basis.


Many hospital services are covered in full after you pay your annual hospital deductible. Some hospital services are covered in full and do not require the payment of a deductible. **If you are non-Medicare-eligible, and you anticipate an inpatient stay or you experience an emergency stay, you must notify UnitedHealthcare's care coordination program.** If you're Medicare-eligible, Medicare coordinates and administers inpatient stays and you do not have to call UnitedHealthcare.

Care Coordination/Notification Procedure

The care coordination program is designed to encourage an efficient system of care for non-Medicare-eligible participants. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. You may also have to notify care coordination for certain therapeutic treatments. The care coordination activities are not a substitute for the medical judgment of your physician, however, and you and your doctor must make the ultimate decision as to what medical care you receive. Care coordination determines whether services or supplies are *covered health services*. No benefits are payable unless care coordination determines the services and supplies are covered under the Plan.

Care coordination is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The services requiring notification include, but are not limited to:

- inpatient stays,
 - emergency admission requires you to call within two business days
 - scheduled inpatient stays require you to call at least five business days before the scheduled admission.
- home health care services,
- durable medical equipment (over \$1,000),
- private-duty nursing,

- 
- prosthetic devices (if a device costs more than \$1,000),
 - reconstructive procedures,
 - accidental dental services,
 - transplant services
 - require at least seven business days before the evaluation, donor search, organ procurement, tissue harvest or transplant.

Call UnitedHealthcare at 1-800-638-5199 for care coordination notification. You can expect to receive inquiries from UnitedHealthcare when certain treatments are involved.

Approval by care coordination does not guarantee that benefits are payable under this Plan. Benefits are based on:

- the covered health services actually performed or given,
- you or your dependent's eligibility on the date the covered health services are performed or given,
- co-payments, deductibles, coinsurance, maximum limits, and all other terms of this Plan.

Care coordination will then complete a review. You, your provider and the facility will be notified confirming the results of the review.

In some instances, benefits are reduced if you do not call care coordination. *If you don't call for certain inpatient stays*, you're responsible for \$100 per day of the charges normally covered under the Plan, up to a maximum of \$500. This amount is payable in addition to the Plan's deductible and does not count toward out-of-pocket limits.

Inpatient Stay Deductible

If you are treated on an inpatient basis in a hospital, skilled nursing facility (also known as a convalescent facility) or hospice, your annual deductible is 50% of the Medicare Part A deductible (inpatient deductible). This deductible changes whenever the Medicare Part A deductible changes. The inpatient deductible is on a per-person/per-year basis. The deductible applies to all inpatient stays, to network and non-network providers, and for each participant regardless of age or Medicare eligibility.

In 2003, the Medicare Part A deductible is \$840, so your inpatient deductible is \$420.

Separate and Related Hospital Visits

Benefits for hospital and skilled nursing facility care are limited to 365 days per person per diagnosis.

Separate stays in a hospital or skilled nursing facility due to the same or a related diagnosis are considered related stays unless you have been out of the hospital or skilled nursing facility for 90 consecutive days between the stays. During a period of related stays per diagnosis, you're required to meet only one inpatient deductible, even if the period runs from one calendar year to the next.

Once related stays total 365 days, benefits are no longer available for inpatient care for that diagnosis. You will be covered if you enter the hospital for another condition, or if you're admitted again after being out of the hospital for 90 consecutive days.

Even if you use all your hospital benefits for one condition, your benefits for that condition can continue for skilled nursing facility care and hospice care.

Covered Hospital Services

If you use a network or non-network provider, after you pay your annual inpatient deductible, the **Retiree Health Plan** pays reasonable and customary charges in full for semi-private room and board for up to 365 days per diagnosis for hospital care.

The daily limit for eligible expenses for room and board is the hospital's standard rate for a semi-private room.

If the hospital does not have semi-private rooms, the **Retiree Health Plan** pays 80% of the charge for the hospital's lowest rate for a private room. The Plan pays full charges for a private room only if you must be isolated because of a communicable disease. In addition to room and board, covered health services include charges for:

- general nursing,
- special care units,
- drugs and anesthetics,
- laboratory tests,
- diagnostic X-rays,
- medical supplies,
- operating and recovery room, *and*
- rehabilitation services.



Benefits for pregnancy-related expenses are determined in the same way as benefits for expenses resulting from sickness.

If you use a network or non-network provider to receive any of the following covered health services, benefits are covered at 100% of the reasonable and customary charges and are not subject to an annual deductible.

- Outpatient surgery charges – charges for surgery in a hospital’s outpatient department, an ambulatory surgical center or a physician’s office. A surgeon’s reasonable and customary charges will be paid in full. An ambulatory surgical center is a specialized facility that is established, equipped, operated and staffed primarily for performing surgical procedures. This type of facility is licensed as an ambulatory surgical center by the appropriate state agency. If the facility is located in a state with no licensing requirements, it may qualify as an ambulatory surgical center because it meets standards set by UnitedHealthcare. To find out whether a particular facility qualifies, call UnitedHealthcare at 1-800-638-5199 or visit <http://www.provider.uhc.com>.
- Hospital emergency room charges – reasonable and customary charges for the care and treatment of an accidental injury or a sudden and serious illness. A serious illness is one that could jeopardize your life or seriously impair your bodily functions if you did not receive medical care.
- Pre-admission testing – X-rays and laboratory tests performed within 10 days before the scheduled surgery. Tests must be related to the illness or injury requiring your scheduled surgery.



Non-Custodial Care in a Skilled Nursing Facility

After you pay your annual inpatient deductible, the **Retiree Health Plan** pays reasonable and customary charges for semi-private room and board for up to 365 days per diagnosis per lifetime for non-custodial care in a skilled nursing facility.

The daily limit for eligible expenses for room and board is the skilled nursing facility's standard rate for a semi-private room.

To receive benefits in a skilled nursing facility, you must remain under a doctor's continuous care and require both 24-hour nursing care and physical restorative services for convalescence from a disease or injury.

Physical restorative services are skilled services designed to improve a patient's physical functioning impaired by disease or injury. Functions that may need to be improved through physical restorative services include walking, endurance and muscle strength.

While in a skilled nursing facility, reasonable and customary charges are covered for the following services:

- X-rays and laboratory work,
- physical, occupational or speech therapy,
- oxygen and other gas therapy, *and*
- other medical services (excluding physician's and private-duty nursing services) and supplies.

Custodial Care

Coverage is not provided for custodial care – non-skilled and non-health related care that involves assisting a person in the usual activities of daily living such as dressing, bathing and preparing meals, and that doesn't involve convalescent care.

Custodial care is made up of services and supplies that are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment. Custodial care is care that can safely and adequately be provided by anyone who does not have the technical skills of a covered health care professional. Care that otherwise meets the condition for being custodial care is custodial care regardless of who recommends, provides or directs the care, where the care is provided, or whether the patient or another caregiver can be or is being trained to care for himself or herself.



Hospice Care

After you pay your annual inpatient deductible, the **Retiree Health Plan** pays 100% of the reasonable and customary charges for a hospice care program for up to 365 days in a lifetime.

To obtain hospice care coverage under the Plan, the doctor who recommends that you enter the program must certify to UnitedHealthcare that you are terminally ill and have no more than six months to live. Charges are paid only for services ordered by the doctor supervising the program.

The daily limit for room and board in a hospice facility is the facility's standard semi-private room rate.

Care provided at a hospice facility includes pain control and other acute and chronic symptom management.

Other covered hospice care charges include:

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

Inpatient Rehabilitative Care

After you pay your annual inpatient deductible, the Plan pays 100% of reasonable and customary charges for inpatient rehabilitative care for up to 100 days in a calendar year. The Plan pays reasonable and customary charges for semi-private room and board and for other covered health services.

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

The Plan pays benefits for inpatient rehabilitative care if care is provided by a hospital or an institution that is not a hospital but is certified, licensed or approved by a federal or state agency to provide rehabilitative care.



Inpatient Treatment for Mental Health Disorders

After you pay your annual inpatient deductible, the **Retiree Health Plan** pays reasonable and customary charges for inpatient treatment of mental health disorders for up to 30 days in a calendar year.

The **Retiree Health Plan** pays benefits if treatment is provided in a hospital or an institution that is not a hospital but is certified, licensed or approved by a federal or state agency.

The **Retiree Health Plan** pays reasonable and customary charges for semi-private room and board and for other covered health services. The Plan's coverage for a mental health disorder does not include benefits for any conditions from alcoholism or drug abuse. The Plan's coverage for inpatient treatment of alcoholism and drug abuse is described in the following section.

Inpatient Treatment of Alcoholism and Drug Abuse

After you pay your annual inpatient deductible, the **Retiree Health Plan** pays 100% of reasonable and customary charges for the diagnosis and treatment of alcoholism or drug abuse. Days of inpatient care are limited as follows:

- up to seven days of alcohol detoxification in any calendar year,
- up to 14 days of drug detoxification in any calendar year, *and*
- treatment is limited to 30 days in a calendar year for alcohol and/or drug abuse.

Inpatient treatment of alcoholism and drug abuse may be provided in a hospital or in an alcohol or drug abuse treatment facility.

Benefits include detoxification from abusive chemicals or substances that are limited to physical detoxification when necessary to protect one's well being and physical health.

Alcohol or Drug Abuse Treatment Center

Under this Plan, an alcohol or drug abuse treatment center is a facility that mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism or drug abuse, makes charges for its services, meets licensing and accreditation standards for the state's facility providing this type of treatment, and prepares and maintains for each patient a written treatment plan based on medical, psychological and social needs.

Effective treatment of alcoholism or drug abuse is in accordance with a treatment plan given to UnitedHealthcare by a doctor, hospital or treatment facility. Detoxification alone or maintenance care alone is not considered effective treatment.

In addition, a facility must provide, on its premises, 24 hours a day:

- detoxification services needed with its effective treatment program,
- infirmary-level medical services. (The facility must either provide any other service or arrange for them to be provided at a hospital in the area),
- supervision by a staff of doctors, *and*
- skilled nursing care by licensed nurses who are directed by a full-time R.N.

Home Health Care

After you pay your annual inpatient deductible, the **Retiree Health Plan** pays 100% of reasonable and customary charges for up to 200 skilled home health care visits in a calendar year provided by a licensed and approved home health care agency.

To qualify for home health care coverage under the **Retiree Health Plan**, your doctor must submit a written skilled home health care plan and you must provide notification through care coordination. The skilled home health care plan must certify that if you did not receive the services and supplies described in the plan, that it would be necessary for you to be confined as an inpatient in a hospital or skilled nursing facility.

The **Retiree Health Plan** pays for the following charges made by an approved skilled home health care agency for covered health services ordered by your doctor and provided at home.

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

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



Approved Home Health Care Hospital or Agency

An approved home health care hospital or agency is any of the following:

- a non-profit or public skilled home health care service or agency certified under a state public health law,
- a hospital with a state license to provide skilled home health care services, *or*
- an agency that provides skilled nursing and other therapeutic services, has a full-time administrator, has full-time supervision by a physician or a registered nurse and keeps medical records.

The skilled home health care program does not include the following:

- transportation services,
- custodial and personal care,
- services provided by someone who lives with you or is a member of your family or your spouse/domestic partner's family, *or*
- any services or supplies that are not part of the skilled home health care plan.





Medical Benefits

Covered health services under the **Retiree Health Plan** includes doctor visits, services, supplies, private duty nursing, and outpatient care for treatment of alcohol and drug abuse.

Although the **Retiree Health Plan** does not generally cover routine health checkups, coverage is included for cytology screenings, well baby care and mammography screenings.

Medical Benefits Deductible

A deductible is required for most medical benefits. However, if you are non-Medicare-eligible and use a network provider, you do not have to meet a deductible.

In 2003, the annual medical deductible is \$500 for each person and \$1,500 for a family. If you have a family of three or more, the maximum amount you will pay is \$1,500. However, no more than \$500 of any one person's covered medical expenses will be applied toward the family medical deductible. Expenses incurred for covered health services during October, November or December are applied to your medical deductible for that year and the next calendar year.

Amounts exceeding reasonable and customary charges, as determined by UnitedHealthcare or Medicare, are not covered under the **Retiree Health Plan** and will not be counted toward your annual deductible or out-of-pocket maximum.



Your Share of Costs

If you use a network provider, your share of costs is a co-payment for office visits and you do not have to meet the annual deductible. If you use a non-network provider, after you pay your annual medical deductible, the Plan generally pays 80% of reasonable and customary charges for most covered health services up to \$12,500 for 2003. You pay the remaining 20% up to \$2,500.

Some covered health services are reimbursed at 50% and some at 100% of reasonable and customary charges after you pay the medical deductible. Some covered health services do not require you to meet the annual medical deductible.

Out-of-Pocket Maximum

After you pay the out-of-pocket maximum, the Plan pays 100% of the reasonable and customary charges during that year up to the lifetime maximum. For 2003, the annual out-of-pocket maximum is \$3,000 per person (\$2,500 plus the \$500 deductible).

Some charges that are not counted toward your out-of-pocket maximum include:

- charges you incur in excess of reasonable and customary charges,
- payments for covered health services not covered under the Plan, including those that are not necessary,
- your 50% co-payment for special services covered at 50%,
- penalties,
- charges you incur in excess of any other limits,
- any office visit co-payment, *and*
- your monthly contributions for participation in the **Retiree Health Plan** and your **Medicare Part B** premiums.

Network Providers

For retirees who are non-Medicare-eligible, you have access to UnitedHealthcare's network providers. For 2003, each office visit requires a co-payment of \$18, and the annual medical deductible and coinsurance provisions do not apply. Your \$18 co-payment is not counted toward your annual medical deductible or out-of-pocket maximum.

In general, if you are non-Medicare-eligible and use a network provider, you will pay an office visit co-payment.

To locate network providers, call UnitedHealthcare at 1-800-638-5199, visit their web site at <http://www.provider.uhc.com>, or visit the **Retiree web site** <http://retirees.coned.com>. The directory shows the names, addresses, telephone numbers and specialties of providers.



Covered Medical Services

Listed below are the covered medical services and supplies. For certain ongoing therapeutic services, such as chiropractic care, your provider may be required to submit treatment plans to UnitedHealthcare.

If you do not use a network provider or are Medicare-eligible and do not have the PPO, the **Retiree Health Plan** pays 80% of reasonable and customary charges for the following covered health services, after you pay your annual medical deductible:

- doctors' services: home and hospital visits and other medical care and treatment,
- inpatient surgical charges,³
- private-duty nursing,
- surgical treatment of severe morbid obesity,
- orthotic appliances only if you have a diabetic diagnosis,
- organ and tissue transplants when ordered by a physician including: heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel, bone marrow transplants (either for you or a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made for the search,
- chiropractic services

³ *Covers fees for surgical procedures and other medical care received in the following settings: inpatient and outpatient hospital, office and alternative facilities (for example, an ambulatory surgical center).*

- nutritional counseling by a registered dietician in an individual session for medical conditions that require a special diet. For example: diabetes mellitus, coronary artery disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemias. Benefits are limited to three lifetime individual sessions for each medical condition,
- X-rays, laboratory services, diagnostic testing, radium and radioactive isotope therapies and chemotherapy,
- surgical dressings, casts, splints and other devices used for reductions, fractures and dislocations,
- rental or purchase of durable medical equipment,⁴
- artificial limbs, larynges, eyes, breast prosthesis and other non-dental prosthetic devices,
- braces, trusses and crutches,
- heart pacemakers,
- treatment of accidentally injured natural teeth within 12 months of the accident, including dental surgery and prosthetic devices,
- blood and blood plasma and their administration when not replaced by or for the patient,
- oxygen,
- renal dialysis,
- acupuncture,

⁴ Notification is required on any durable medical expense over \$1,000. Care coordination will decide if the equipment should be purchased or rented. The equipment must be purchased or rented from the vendor care coordination identifies.

- anesthetics and their administration,
- local ambulance services,
- initial examination and manual manipulation of the spine to correct a subluxation that can be demonstrated by X-rays,
- medical charges related to pregnancy,
- physical, occupational and speech therapy when necessary, up to 30 visits with a licensed therapist,
- pulmonary rehabilitation therapy,
- cardiac rehabilitation therapy,
- crisis intervention up to three visits in a calendar year,
- hospital services and supplies not covered under the hospital part of this Plan, *and*
- second surgical opinion.



Special Services Covered at 50%

After you pay your annual deductible, the Plan covers the reasonable and customary charges for the following services at 50%:

- other services (which may include whirlpool bath, ultrasound treatments, electrical stimulation and traction) performed in connection with the manipulation of the spine to correct a subluxation, up to an annual maximum of \$500 per person,
- routine foot care, up to an annual maximum of \$250 per person, including: treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions. If you use a network provider there is no deductible, but the annual maximum of \$250 applies and you must pay an office visit co-payment for each visit.

You're responsible for paying the remaining 50% of these charges. This payment does not count toward your out-of-pocket maximum.

Spinal Manipulation

If you use a network provider, the usual co-payment for an office visit applies and there is no deductible for the examination and spinal manipulation. However, other services, as shown below, are subject to an annual \$500 calendar year maximum.

The following chart shows the benefits paid at 80% and 50%, for services relating to the correction of spinal subluxations (dislocation of the vertebrae) if you use a non-network provider.

Correction of Spinal Subluxations			
Treatment:	After deductible is met, Plan pays:	You pay:	Subject to \$500 calendar year maximum:⁵
• Initial examination (including x-rays and associated tests)	80%	20%	No
• Spinal manipulations	80%	20%	No
• Other services performed in connection with correction of spinal subluxation. <i>Other services may include whirlpool bath, ultrasound treatments, electrical stimulation, and traction, etc.</i>	50%	50%	Yes

⁵ for network and non-network providers.



Physical Examinations and Immunizations for a Dependent Child

The Plan pays 100% of reasonable and customary charges for physical exams and immunizations for a dependent child and no deductible or co-payment applies. Routine and preventive care is covered for dependent children up to age 19 or age 23 for full-time students. This coverage includes a routine physical examination (including immunizations and laboratory examinations).

Routine immunizations that are covered include diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type B and hepatitis B.

Cytology Screenings

If you use a network provider, the usual co-payment applies for an office visit and there is no deductible.

If you use a non-network provider, after you pay the medical deductible, the **Retiree Health Plan** pays 80% of reasonable and customary charges for an annual cytology screening for women age 18 and older.

A cytology screening includes a pelvic examination, collection and preparation of a pap smear and laboratory and diagnostic services provided in connection with examining and evaluating the pap smear.



Services Covered at 100% – With Deductible

If you use a network or non-network provider, after you pay your annual medical deductible, the Plan pays 100% of reasonable and customary charges for:

- **Hearing aids** – up to a lifetime maximum of \$300 per ear for the purchase, examination and fitting of hearing aids.

Services Covered at 100% - No Deductible

If you use a network or non-network provider, and you have not met your annual medical deductible, the Plan pays 100% of reasonable and customary charges for the following necessary services:

- **Outpatient surgery** – surgical services performed in a doctor's office, a hospital's outpatient department or an ambulatory surgical center. This includes lab and radiology/X-rays and other diagnostic tests and therapeutic treatments.
- **Routine mammography screening** for breast cancer, according to the following schedule:
 - on the recommendation of a physician, a mammogram at any age for covered persons with a previous history of breast cancer or whose mother or sister have a prior history of breast cancer,
 - a single baseline mammogram for covered persons age 35 through 40, *and*
 - a mammogram once every year, or more frequently upon the recommendation of a physician, for covered persons age 40 and over.

Determining Private-Duty Nursing Coverage

Most hospital patients don't need private-duty nursing care since hospitals are responsible for providing nursing services for their patients. Although a doctor may recommend the services of a private-duty nurse while a patient is in the hospital, this level of individual care is often not necessary and is not covered by the **Retiree Health Plan**.

After leaving the hospital, patients generally need some time at home to recuperate. Usually, a patient needs ongoing medical services while they are recuperating. In special circumstances, including certain chronic conditions, a doctor may recommend private-duty nursing care at home. In this case, even if nursing care is provided for only one or two hours a month, you must notify UnitedHealthcare at 1-800-638-5199.

If part-time or intermittent nursing care is provided (instead of hospitalization under a home health care plan approved by UnitedHealthcare), this care is considered home health care, not private-duty nursing, and is covered under the Plan's home health care hospital benefits.



Private-Duty Nursing

After you pay the annual medical deductible and provide the proper notification to care coordination, the Plan pays 80% of the reasonable and customary charges for private-duty nursing by a R.N. or L.P.N.

Private-duty nursing consists of skilled services performed by an R.N. or L.P.N. who is not providing these services as an employee of a hospital or other health care institution or as a member of a home health care team.

Private-duty nursing services include, but are not limited to:

- administering medication requiring injection,
- monitoring vital signs and symptoms when the patient has a life-threatening illness,
- administering intravenous (IV) solutions as prescribed by a doctor, *and*
- cleaning and dressing open or infected wounds.

Private-duty nursing services *do not include*:

- charting of vital signs,
- custodial care such as bathing, shaving and changing clothes and bed linens,
- household services such as cleaning, cooking and laundry,
- attending a patient for the purpose of companionship or observation,
- transportation services, *or*
- assistance in the activities of daily living.

Outpatient Treatment of Alcoholism and Drug Abuse

After you pay the annual deductible, the **Retiree Health Plan** pays 80% of reasonable and customary charges for up to 60 visits for alcohol or drug abuse.

Up to 20 of these visits may be used for counseling family members covered under the Plan, even if the patient's treatment hasn't yet begun. Coverage for family counseling is limited to a total of 20 visits for all family members, and each family member is limited to one visit a day.

Outpatient Treatment for Mental Health Disorders

After you pay the annual deductible, the Plan pays 80% of reasonable and customary charges up to \$70 per visit. The maximum reimbursement is \$56 per visit.



Special Features

UnitedHealthcare offers you a valuable resource, *Optum NurseLine*, where you can obtain information about your health concerns. The *Optum NurseLine* offers you the opportunity to speak with registered nurses 24 hours a day, seven days a week, by calling 1-866-202-4852. Nurses are prepared to answer health questions, share self-care techniques, offer tips for staying healthy, recommend web pages for further research, and more. You can also access an audio *Health Information Library*, allowing you to listen to recorded health messages on such topics as diabetes, heart health, weight control, and smoking.

In addition UnitedHealthcare offers:

- *A Treatment Cost Estimator:* This service will help you understand and manage your health care costs and includes estimates of out-of-pocket costs for both network and non-network providers. You can access the treatment cost estimator by visiting <http://www.myuhc.com>.
- *Cancer Resource Services:* Nurse-consultants will help you identify where to get care and provide you with relevant information on cancer centers and clinical topics. You can reach them by calling 1-866-936-6002. This service also provides you access to a medical director who will discuss your case with you and connect your referring physician with cancer experts at the *Cancer Resource Services* centers.



Medicare Benefits

Benefits for Medicare-Eligible Participants

If you're a Medicare-eligible participant, the **Retiree Health Plan** offers you a supplemental medical plan with UnitedHealthcare. The Plan works together with your Medicare coverage and automatically offsets Medicare approved charges for reimbursement. You must have **Medicare Part B** coverage as well as **Part A** coverage to ensure that you receive the highest level of benefits available to you under the Plan.

UnitedHealthcare follows these steps to calculate your benefit:

1. UnitedHealthcare uses Medicare's approved charge (the reasonable and customary charge) for covered health services.
2. UnitedHealthcare reduces the Medicare approved charge by the amount that Medicare paid or would have paid if you were enrolled in **Medicare Part B**.
3. UnitedHealthcare applies the **Retiree Health Plan's** appropriate deductible (hospital or medical).
4. UnitedHealthcare calculates the amount that the Plan pays of the remaining amount based on the covered health services and how the Plan pays for those services. *For example*, 100% for most inpatient stays, 80% for most medical expenses, and 50% for some special services.



Applying for Medicare Benefits

You must contact your local Social Security office at *least three months before your 65th birthday* to apply for both **Medicare Part A** and **Part B** benefits. You should also call UnitedHealthcare to apply for *Medicare Crossover*.

Please note, if you are eligible for **Medicare Part A**, you must also apply for **Medicare Part B** to obtain the full benefits under the **Retiree Health Plan**.

Your Medicare benefits become effective on the first day of the month in which you are eligible for Medicare.

If you or your eligible dependents were born on the first day of the month, your Medicare benefits become effective on the first day of the prior month. *If your dependent becomes Medicare-eligible, you must notify Employee Benefits.*

You should also notify Employee Benefits if you become eligible for Medicare benefits before you reach age 65.

At the time you become eligible for Medicare, if you have already been paying for coverage under the *Retiree Health Program*, your monthly contribution is reduced.

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

Examples – How Plan Benefits Are Paid

In general, after a Medicare-eligible participant incurs a service charge for hospital or medical expenses, first Medicare pays a share of the provider fees based on established reasonable and customary charges. The **Retiree Health Plan** then pays a percentage of the remaining charges according to Medicare’s reasonable and customary fees for services provided. The participant is responsible for the annual hospital and medical deductibles as well as any expenses above those covered by Medicare and the **Retiree Health Plan**.

For example:

A participant incurs a \$3,500 doctor’s charge. The participant has not met his annual medical deductible.

<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">\$</td> <td style="width: 15%;">3,500</td> <td style="width: 25%;"><i>(Medicare approved charge)</i></td> </tr> <tr> <td>-</td> <td>\$ 100</td> <td><i>(Medicare Part B deductible)</i></td> </tr> <tr> <td colspan="3"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td></td> <td>\$ 3,400</td> <td></td> </tr> <tr> <td>x</td> <td>80%</td> <td><i>(reimbursed at 80%)</i></td> </tr> <tr> <td colspan="3"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td></td> <td>\$ 2,720</td> <td><i>(amount paid by Medicare)</i></td> </tr> </table>	\$	3,500	<i>(Medicare approved charge)</i>	-	\$ 100	<i>(Medicare Part B deductible)</i>	<hr style="border: 0; border-top: 1px solid black;"/>				\$ 3,400		x	80%	<i>(reimbursed at 80%)</i>	<hr style="border: 0; border-top: 1px solid black;"/>				\$ 2,720	<i>(amount paid by Medicare)</i>	<table border="0" style="width: 100%;"> <tr> <td style="width: 10%;">\$</td> <td style="width: 15%;">3,500</td> <td style="width: 25%;"><i>(submitted to Plan)</i></td> </tr> <tr> <td>-</td> <td>\$ 2,720</td> <td><i>(amount paid by Medicare)</i></td> </tr> <tr> <td colspan="3"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td></td> <td>\$ 780</td> <td></td> </tr> <tr> <td>-</td> <td>\$ 500⁶</td> <td><i>(annual medical deductible)</i></td> </tr> <tr> <td colspan="3"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td></td> <td>\$ 280</td> <td></td> </tr> <tr> <td>x</td> <td>80%</td> <td><i>(Plan pays 80% of covered charges)</i></td> </tr> <tr> <td colspan="3"><hr style="border: 0; border-top: 1px solid black;"/></td> </tr> <tr> <td></td> <td>\$ 224</td> <td><i>(paid by UnitedHealthcare)</i></td> </tr> </table>	\$	3,500	<i>(submitted to Plan)</i>	-	\$ 2,720	<i>(amount paid by Medicare)</i>	<hr style="border: 0; border-top: 1px solid black;"/>				\$ 780		-	\$ 500 ⁶	<i>(annual medical deductible)</i>	<hr style="border: 0; border-top: 1px solid black;"/>				\$ 280		x	80%	<i>(Plan pays 80% of covered charges)</i>	<hr style="border: 0; border-top: 1px solid black;"/>				\$ 224	<i>(paid by UnitedHealthcare)</i>
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<p>Patient responsibility = \$556 <i>(\$500 annual medical deductible + \$56 [20% of \$280])</i></p>																																																				

⁶ *If the annual medical and Medicare deductibles have already been satisfied, the Plan pays \$560 [(amount paid by Medicare: \$3,500 x 80% = \$2,800) (amount paid by the Plan: \$3,500 - \$2,800 = \$700 x 80% = \$560)].*

The following examples show how the **Retiree Health Plan** and **Medicare** (when applicable) pay hospital and medical service charges for two retirees, Jean, age 62 and Joe, age 67. Joe is covered by Medicare.

Example A: Retiree Under Age 65 – Without Medicare Coverage

In 2003, Jean is hospitalized for surgery and files her first claim of the calendar year. She does not use a network provider. She incurs the following covered health service charges, all considered reasonable and customary under the Plan:

\$ 8,000	<i>Hospital charges</i>
+ \$ 10,000	<i>Medical charges, including surgeon's fees and charges for anesthesiology and radiology</i>
<hr/>	
\$ 18,000	<i>Total charges</i>

After Jean submits a claim, the Plan pays:

<i>Hospital charges</i>	
\$ 8,000	
- \$ 420	<i>Plan's annual hospital deductible paid by Jean</i>
<hr/>	
\$ 7,580	<i>Amount paid by Plan (inpatient stay covered at 100% of R&C charges)</i>
 <i>Medical charges</i>	
\$ 10,000	
- \$ 500	<i>Plan's annual medical deductible paid by Jean</i>
<hr/>	
\$ 9,500	
x 80%	<i>Plan pays 80% of covered charges</i>
<hr/>	
\$ 7,600	<i>Amount paid by Plan</i>

Summary of how Jean's hospital and medical charges are paid:

\$ 15,180	<i>Amount paid by Plan (\$7,580 [Hospital charges at 100% after deductible] plus \$7,600 [Medical charges at 80% of \$9,500])</i>
+ \$ 2,820	<i>Amount paid by Jean [\$420 annual hospital deductible + \$500 annual medical deductible + \$1,900 (\$9,500 x 20% of R&C charges)]</i>
<hr/>	
\$ 18,000	<i>Total charges</i>

Example B: Retiree Covered by Medicare – Parts A and B

Joe is hospitalized for 10 days in August 2003 and files his first claim of the calendar year. He incurs the following covered charges, all considered reasonable and customary under the Plan:

\$ 12,000	<i>Hospital charges</i>
+ \$ 3,000	<i>Medical charges, including surgeon's fees and charges for anesthesiology and radiology</i>
\$ 15,000	<i>Total charges</i>

First Joe submits a claim to Medicare, Medicare pays:

<i>Hospital charges</i>	
\$ 12,000	<i>Medicare approved charges</i>
- \$ 840	<i>Medicare Part A deductible paid by Joe</i>
\$ 11,160	<i>Hospital expenses paid by Medicare</i>

<i>Medical charges</i>	
\$ 3,000	<i>Medical charges</i>
- \$ 100	<i>Medicare Part B deductible paid by Joe</i>
\$ 2,900	
x 80%	<i>Medicare approved charge x 80%</i>
\$ 2,320	<i>Medical expenses paid by Medicare</i>



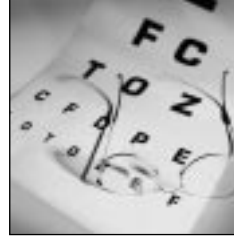
Next, Joe submits a claim to the Plan. The Plan pays:

<i>Hospital charges</i>	
\$ 12,000	<i>Hospital charges</i>
- \$ 11,160	<i>Amount paid by Medicare</i>
<hr/>	
\$ 840	
- \$ 420	<i>Plan's annual hospital deductible paid by Joe</i>
<hr/>	
\$ 420	<i>Amount paid by Plan</i>

<i>Medical charges</i>	
\$ 3,000	<i>Medical charge</i>
- \$ 2,320	<i>Amount paid by Medicare</i>
<hr/>	
\$ 680	
- \$ 500	<i>Plan's annual medical deductible paid by Joe</i>
<hr/>	
\$ 180	
x 80%	<i>Plan pays 80% of covered charges</i>
<hr/>	
\$ 144	<i>Amount paid by Plan</i>

Summary of how Joe's hospital and medical charges are paid:

\$ 13,480	<i>Amount paid by Medicare</i>
+ \$ 564	<i>Amount paid by Plan</i>
+ \$ 956	<i>Amount paid by Joe [\$420 annual hospital deductible + \$500 annual medical deductible + \$36 (\$180 x 20% of R&C charges)]</i>
<hr/>	
\$ 15,000	<i>Total charges</i>



Vision Care Benefits

Vision care benefits are included as part of the **Retiree Health Plan**. Benefits are provided for routine vision care examinations and to help defray the cost of eyeglasses – including lenses, frames or contact lenses – if the eyeglasses or contact lenses are required to correct your vision.

Vision care benefits are provided, to both Medicare and non-Medicare-eligible participants, at either no cost or a reduced cost when you use a *network vision provider* affiliated with *General Vision Services, Comprehensive Professionals and Vision World*. If you use a *non-network vision provider* services are covered according to the amounts on the following pages.

Network Vision Providers

The company has made special arrangements with vision care providers to supply certain vision care services to you and your eligible dependents at no cost or at a reduced cost. These providers are called network vision providers and are one of three separate networks including *General Vision Services, Comprehensive Professionals and Vision World*.

A list of network vision providers is available from Employee Benefits by calling 1-800-582-5056, or on the **Retiree web site** at <http://retirees.coned.com>.

Vision care services are separate and distinct from the provisions of the Retiree Health Plan and are subject to change at any time.



Covered Services

The Plan covers a vision examination performed by a doctor (ophthalmologist or optometrist) licensed to perform vision examinations and prescribe lenses. **Vision care benefits are not subject to the Retiree Health Plan deductible or coinsurance. The expenses you incur do not go towards your annual out-of-pocket limit.** However, all vision care expenses incurred by the Retiree Health Plan are included in your lifetime maximum benefit.

In every 24 consecutive calendar months (2 years), each covered person is eligible for one eye examination and one pair of eyeglasses or contact lenses including:

- a case history,
- tests of visual acuity (clearness of vision),
- external examination and measurement,
- interior examination with ophthalmoscope,
- examination of papillary reflexes and eye movements,
- retinoscopy (shadow test),
- subjective refraction,
- coordination measurements (far and near),
- tonometry (glaucoma test),
- medicating agents for diagnostic purposes (if applicable), *and*
- an analysis of the findings with recommendations and a prescription (if required).

Eyeglasses or Contact Lenses – The Plan covers glass or plastic lenses prescribed by an ophthalmologist or optometrist, as well as frames adequate to hold the lenses. Lenses must meet the standards of the American National Standards Institute. You may choose contact lenses instead of eyeglasses.

Services Available From Network Vision Providers

No-Cost Services

The following services are available to you at no cost when you visit a network vision provider:

- comprehensive eye examination, including testing for glaucoma,
- a lens or lenses including single vision bifocals, trifocals or lenticular lenses, glass or plastic lenses, and tinting of glasses, *and*
- a frame with a retail value up to \$70.

If a state law requires you to go to a separate facility for eye examinations, the Plan will reimburse you according to the maximum benefits.



Reduced-Cost Services

Additional services available to you through vision network providers include a frame with a retail value over \$70. If you choose a frame with a retail value greater than \$70, you're responsible for paying the difference.

For example:

If the frame you choose costs \$100, your payment is \$30 ($\$100 - \70).

Additional services include contact lenses instead of lenses and a frame. A \$70 credit is applied toward the regular retail price of contact lenses at vision network providers. You're responsible for paying 70% of the difference between the retail price and the \$70 credit.

For example:

If the regular retail price is \$250, your payment is \$126 toward the cost of your contact lenses ($\$250 - \$70 = \$180$; $70\% \times \$180 = \126).

Optional Services

Optional services are also available at network vision providers for the following amounts:

- photosensitive single-vision lenses – \$7.50
- photosensitive bifocal lenses – \$15
- invisible bifocal lenses – \$25
- second pair of glasses – 30% discount from the regular retail price.

Services from a Non-Network Vision Provider

The **Retiree Health Plan** will pay up to the following maximum amounts for covered services from a non-network vision provider:

- an eye examination – \$20
- eyeglasses – \$25 for lenses and \$20 for frames
- contact lenses – \$45 instead of eyeglass lenses and frames.

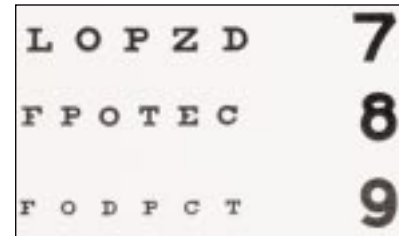
To obtain benefits from a non-network vision provider, you must submit a claim form for reimbursement.

How To Obtain Vision Care Benefits

When you visit a vision network provider, show your Con Edison **Retiree Health Plan** Identification Card and complete and sign a **Retiree Health Plan** claim form. The vision provider sends the form to UnitedHealthcare who reimburses the provider directly.

When you visit a non-network vision provider, bring a claim form with you and ask the vision provider to sign it. After you complete the form, send it to UnitedHealthcare along with your bill from the vision provider.

Retiree Health Plan claim forms used for vision care benefits are the same forms used for hospital and medical benefits. Forms are available on the **Retiree web site** at <http://retirees.coned.com> or by calling UnitedHealthcare at 1-800-638-5199.



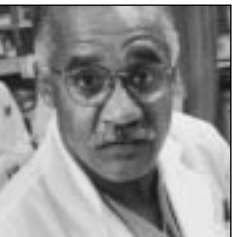
Services Not Covered Under The Retiree Health Plan

If you incur charges for services not covered under the **Retiree Health Plan**, the charges for these services do not count toward your Plan deductibles or out-of-pocket maximum.

As health care continues to change, it is not always possible to determine whether a service or supply will be covered. If a service or supply is not specifically listed below, it still may not be covered. If you have any questions you should call UnitedHealthcare before you incur any expense for a service or supply.

The following are not covered:

- charges for education, special education or job training whether given in a facility that also provides medical or psychiatric treatment,
- services or supplies not necessary, for the diagnosis, care or treatment of the physical or mental condition involved, even if prescribed, recommended or approved by the attending physician,
- services or supplies provided under law by any school, college, or institution of learning,
- a portion of any charges for services and supplies that UnitedHealthcare or Medicare determines is in excess of reasonable and customary charges,
- charges that are made only because coverage exists,
- charges that a covered individual is not legally obligated to pay,
- services or supplies furnished by or for the U.S. Government or any other government unless payment is legally required,



- charges for or in connection with speech therapy,
 - exclusion does not apply to charges for speech therapy that is expected to restore speech to an individual who has lost an existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury,
- services or supplies paid by any government program or law – other than Medicaid – under which you are, or could be covered,
- services or supplies paid by no-fault insurance,
- prescribed or non-prescribed medical supplies unless for use with a prescribed and covered piece of Durable Medical Equipment. Disposable supplies including, but not limited to, ace bandages, gauze and dressings, diabetic test strips, and orthotic appliances that straighten or reshape a body part (or for any reason other than for the treatment of diabetes). Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment,
- treatment of an injury arising out of, or in the course of, any employment for wage or profit, or to treat an illness covered by a workers compensation law, occupational disease law or similar legislation,
- routine check-ups or annual physical examinations, immunizations, and any other services or supplies that are not necessary for medical care of an accidental injury or illness, except as previously described,
- charges for or in connection with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial,
- charges for procedures, services, drugs and other supplies that are experimental, unproven or still under clinical investigation by health professionals. The fact that an experimental or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the service or treatment is considered experimental, unproven or under clinical investigation,

- actual or attempted impregnation or fertilization including surrogate parenting, fees or direct payment to a donor for sperm or ovum donations, or monthly fees for maintenance and/or storage of frozen embryos, diagnosis and treatment of infertility when provided by or under the direction of a physician, artificial insemination, and invitro fertilization, gamete intrafallopian transfer procedures, zygote intrafallopian transfer procedures and any related prescription medication treatment,
- charges for the reversal of a sterilization procedure,
- charges for therapy, supplies, or counseling for sexual disfunctions or inadequacies,
- charges for or related to sex change surgery or any treatment of gender identity disorders,
- charges for any services or supplies if the provision is prohibited by any law of the jurisdiction in which the individual resides at the time the service or supply is received,
- any services or supplies provided to treat injuries or sickness caused by an act of war that occurs while you are covered by the **Retiree Health Plan**,
- aromatherapy, herbal related medicine, holistic or homeopathic care, hypnotism, massage therapy and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institute of Health,
- megavitamin and nutrition based therapy, nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs or enteral feedings and other nutritional and electrolyte supplements (infant formula, donor breast milk, nutritional and dietary supplements, diets for weight control or treatment of obesity, food of any kind, oral vitamins and oral minerals),
- appliances for snoring,



- cosmetic procedures including, but not limited to the following:
 - pharmacological regimens, nutritional procedures or treatments
 - scar or tattoo removal or revision procedures (such as abrasion, chemosurgery and other skin abrasion procedures),
 - skin abrasion procedures including those preformed as a treatment for acne,
 - replacement of existing breast implant if the earlier breast implant was performed as a cosmetic procedure (replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a mastectomy),
 - physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation,
 - hair transplants (wigs and hairpieces are not covered unless the hair loss is due to chemotherapy or radiation),
 - weight loss programs whether they are under medical supervision, weight loss programs for medical reasons are also excluded.
- not prescribed, recommended and approved by your attending physician,
- inpatient stays for an excluded service,
- custodial care, whether provided at home or in a nursing home or other institution,
- ambulance services when used as routine services,

- blood or blood plasma that is replaced by or for the patient,
- any care provided by you, your spouse or a child, brother, sister or parent of you or your spouse,
- personal comfort items, such as television, telephone, beauty/barber service, guest service, air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers,
- treatment of flat feet, subluxation of the foot, shoe orthotics, hygienic and preventive maintenance foot care/cleaning and soaking the feet,
- applying skin creams to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involved,
- false teeth,
- doctor's services or X-rays involving one or more teeth, the tissue or structure around them, the alveolar process of the gums,
 - exclusion applies even if the condition being treated involves a part of the body other than the mouth such as temporomandibular joint disorders or malocclusion involving joints or muscles.
 - exclusion does not apply to treatment or removal of a malignant tumor in the mouth or to treatment due to accidental injury to natural teeth performed within 12 months of the accident.



- cancelled office visits of missed appointments,
- ecological and environmental medicine, diagnosis and treatment,
- vision training and eye surgery to correct nearsightedness, farsightedness or astigmatism,
- special supplies such as non-prescription sunglasses and subnormal vision aids,
- anti-reflective coatings,
- replacement of lenses or frames that are lost, stolen or broken,
- duplicate or spare eyeglasses or frames for eyeglasses,
- lenses and frames furnished or ordered because of an exam that was done before the person became eligible for coverage,
- any eye or ear exam that is required by an employer as a condition of employment, that an employer is required to provide under a labor agreement, or that is required by any law of any government,
- any hearing care services or supplies that do not meet professionally accepted standards,
- any hearing aid that is experimental or unproven *and*,
- any supply or service received before the date the person became eligible for coverage.



How to File a Claim for Benefits Under the Retiree Health Plan

If you are non-Medicare-eligible and you use a network provider:

You do not have to fill out a claim form. The provider will submit a claim form on your behalf. Payment is made directly to the provider. You must show your UnitedHealthcare identification card when visiting a network provider and pay the applicable co-payment. If you do not show your identification card, network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. You will receive a Explanation of Benefits (EOB) when the claim is processed.

If you are non-Medicare-eligible and you use a non-network provider:

If the provider does not submit claims electronically, you will need to fill out a UnitedHealthcare claim form. You should complete your portion of the form and submit it to UnitedHealthcare along with an itemized bill. Claim forms are available by calling UnitedHealthcare or Employee Benefits or visiting the **Retiree web site** at <http://retirees.coned.com>. Your provider may ask you to show your UnitedHealthcare identification card, and depending on the provider, you may be required to pay in full for the service rendered.

Please follow any care coordination notification procedures that apply to your particular service, supply or treatment to avoid problems with your service, supply or treatment claim.

If you are Medicare-eligible:

You must first file your claim with Medicare. When you receive the Explanation of Medicare Benefits (EOMB) statement, attach a copy of it to the UnitedHealthcare claim form before mailing the form to UnitedHealthcare. You can make your claim process easier and more efficient by enrolling in *Medicare Crossover* described on the following page. Medicare administers procedures for hospital admissions and inpatient stays. You do not have to call UnitedHealthcare.



Processing Your Non-Network Claim

To speed up the processing of your non-network claim, follow the instructions on the claim form carefully. Be sure that all questions are answered fully, indicate whether you want UnitedHealthcare to pay your health care provider directly – and submit any required bills with the form. Mail the completed form to UnitedHealthcare at the address shown on the form. When your claim is processed, UnitedHealthcare will send you a check for any benefits payable to you and an Explanation of Benefits (EOB) statement. Generally, claims should be filed within 90 days but no later than one year from the date a service is provided.

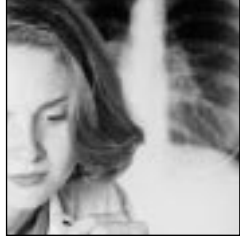
Tips on Filing Claims

To get help when you have a claim problem or a question about how to submit your claim, you can call a UnitedHealthcare claims representative at 1-800-638-5199. Representatives are available weekdays from 8 a.m. to 6 p.m., EST (except holidays).

Below are some suggestions for organizing your medical records and filing claims:

- Keep a separate updated record of the health care expenses of each member of your family covered under the **Retiree Health Plan**.
- Save all your bills – in most cases bills are needed as proof of your expenses.
- Each bill should show the patient's full name, date or dates service was provided or when the purchase was made, nature of illness or injury, type of service or supply provided and itemized charges.
- Before filing a claim, review your bills and this booklet. Be sure the claim you file is for expenses covered under the Plan.
- If you're also covered by Medicare, first file your claim with Medicare. When you receive the Explanation of Medicare Benefits (EOMB) statement, attach a copy of it to the UnitedHealthcare claim form before mailing this form to UnitedHealthcare.
- If you're eligible for Medicare, you can make your claim process easier and more efficient by enrolling in *Medicare Crossover*.





Medicare Crossover

If you're enrolled in Medicare and the **Retiree Health Plan**, you can use *Medicare Crossover*, a service that allows you to file your claim forms electronically. If you sign up for *Medicare Crossover*:

- Your provider will submit a claim to Medicare for your expenses.
- After Medicare pays its portion of the claim to your provider, Medicare sends the claim to UnitedHealthcare electronically – you no longer have to submit claims to UnitedHealthcare through the mail.
- You receive your supplemental benefit in the mail from UnitedHealthcare.

You can sign up for *Medicare Crossover* by completing a *Medicare Crossover* enrollment form. To obtain a form, call UnitedHealthcare at 1-800-638-5199.



HMOs

HMO Highlights

The **Health Maintenance Organization (HMO)** offers health care benefits. **HMOs** are an alternative to the **Retiree Health Plan**. Currently, **HMOs** are located throughout the greater New York area, New Jersey, Connecticut, Florida and some parts of Maryland, Pennsylvania, New Hampshire and Massachusetts. A list of **HMOs** and their toll-free telephone numbers are shown in the back of the booklet.

For retirees who are non-Medicare-eligible: **HMOs** provide health care benefits similar to those currently available under the **Retiree Health Plan**.

For retirees who are Medicare-eligible: Instead of Medicare, **HMOs** provide traditional Medicare benefits such as coverage for doctor visits, hospital care, and tests. In addition, the **HMOs** provide prescription drugs, and some provide preventive and dental care.

How HMOs Provide Medicare Benefits

The Committee on Medicare and Medicaid (CMM) of the U.S. Department of Health and Human Services has contracted with select **HMOs** to provide health care to Medicare participants. The contracts require the **HMOs** to provide comprehensive health care benefits – 100% coverage – for services covered by Medicare **Parts A and B**.

Under the *Retiree Health Program*, some of those selected **HMOs** have contracted with the company to provide additional health care and prescription drug coverage for you and your dependents. Benefits offered by **HMOs** under the Program provide more comprehensive coverage than if you were to enroll in an **HMO** on your own. Co-payments and deductibles are subject to change each year within the full discretion of the **HMO**.

Generally, services outside of the **HMO** are not covered unless approved by the **HMO**, or if services are for emergency care.

How HMOs Work

An **HMO** is a group of doctors, hospitals, health care centers, laboratories, pharmacies and other health care providers who work together to offer health care services to patients.

There are two basic types of **HMOs**:

- a staff model **HMO** that provides services at a medical center affiliated with the **HMO** *and*
- an individual practitioner association (IPA) model **HMO** that is a group of doctors in private practices who provide services to **HMO** members.

If you enroll in an **HMO**, you must use the **HMO** doctors and facilities for all your health care. To help you do this, you choose a personal doctor – called a primary care physician or PCP – from among the **HMO's** group of doctors. A primary care physician is generally an internist or family practitioner who has been retained by the **HMO** and has passed the **HMO's** and Medicare's credentialing criteria. The primary care physician you select:

- studies your medical history and monitors your health to coordinate the care you receive,
- oversees your checkups, tests and preventive care, and monitors any medications you may be taking, *and*
- when necessary, arranges referrals to specialists or hospital admissions.

If at any time you don't feel comfortable with the physician you have selected, you can choose a new primary care physician from your **HMO's** list of doctors who are accepting new patients.

At some point, you or a family member may need to be admitted to the hospital. When your primary care physician or a specialist referred by your PCP recommends a hospital stay, an **HMO** doctor makes the appropriate arrangements and schedules any tests you need. The **HMO** takes care of all paperwork for hospital admissions – you do not have to complete any forms.

All **HMOs** include non-network coverage for emergency care only. If you have a medical emergency while you're traveling and can't see your primary care physician or go to an **HMO** hospital, you're covered under your **HMO**. Non-network coverage for each **HMO** is defined in the written material provided by the **HMO**.





Prescription Drug Benefits

If you are enrolled in a HMO, this Prescription Drug Plan is not available to you, and coverage is provided through your HMO. The Plan provisions pertain to Medicare and non-Medicare-eligible participants.

The **Prescription Drug Plan** provides benefits for prescription drugs through a *prescription card program* (retail pharmacy) and a *mail-order prescription program*. Currently, the Plan is administered by Caremark, Inc. with a separate deductible, co-payments and a monthly contribution.

In 2003, there is a \$30 monthly contribution for retirees or surviving spouses who do not have covered dependents and a \$50 monthly contribution if you are enrolled under family coverage.

Within the *prescription card program*, after you meet the annual per person deductible, you pay a specific co-payment for each prescription from your retail pharmacy for up to a 34-day supply.

Within the *mail-order prescription program*, there is no deductible and you pay a specific co-payment for each prescription for up to a 90-day supply.

The amount of your co-payment depends on whether your prescription is filled with a generic or name-brand drug – generic drugs cost less than name-brand drugs. As consumers, you immediately save when you choose a generic drug because your cost is lower. According to the Food and Drug Administration (FDA), generic drugs contain exactly the same active ingredients as the name-brand drugs and are just as safe and effective.

Current Plan deductibles and co-payments are shown in the *Schedule of Contributions and Co-Payments* in the back pocket of this booklet and on the **Retiree web site** at <http://retirees.coned.com>.

Covered Drugs

The **Prescription Drug Plan** covers most legend drugs (drugs that cannot be dispensed without a prescription) and medicines that require a prescription from a doctor.

Specific Illnesses or Services – If your healthcare professional prescribes medications addressing the following therapies or medications below, then call Caremark at 1-800-237-2767 or visit <http://www.caremark.com> to coordinate coverage:

- *Growth Hormone* – Nutropin AQ[®], Nutropin Depot[®], Nutropin[®], Protropin[®], Humatrope[®], Geref[®], Genotropin[®], Norditropin[®], Saizen[®], Lupron[®]
- *Multiple Sclerosis* – Copaxone[®], Avonex[®], Betaseron[®], Novantrone[®], Rebif[®]
- *Hepatitis B & C* – PEG-Intron[™] /Rebetol[®], Rebetron[®], Roferon[®], Infergen[®]
- *Arthritis (Osteo and Rheumatoid)* – Kineret[™], Enbrel[®], Remicade[®], Synvisc[®], Hyalgan[®]
- *Respiratory Syncytial Virus (RSV)* – Synagis[®]
- *Pulmonary Hypertension* – Tracleer[™]
- *Anemia* – Epogen[®], Procrit[®], Neupogen[®], Leukine[®], Aranesp[™], Neumega[™]

Call 1-866-792-2731 or visit Caremark's web site to coordinate your coverage for the therapies or medications listed below:

- *Immune Deficiency* – IGIV and others
- *Bleeding Disorders*– Recombinant and Monoclonal Factors VIII & IX, Stimate[®]



Maintenance Prescription Drugs – Insulin and maintenance prescription drugs are covered under the **Prescription Drug Plan**. Under the *prescription card program*, maintenance prescription drugs may be dispensed in amounts up to 100-unit doses, but never more than a 34-day supply. It may be more economical to obtain these drugs through the *mail-order prescription program*, which can provide up to a 90-day supply.

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

In addition, oral contraceptives with a medical diagnosis are covered under the *mail-order prescription program*.

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

Caremark Network Pharmacies

If you have a prescription filled at a network retail pharmacy, after you meet your annual deductible, you will only be charged the applicable co-payment.

Most pharmacies participate in the Caremark *prescription card program*. For a complete listing of Caremark's network pharmacies, visit <http://www.caremark.com> or call 1-800-601-6364.

Filling a Prescription at Non-Network Pharmacies

If you have a prescription filled at a non-network pharmacy, you will be charged the full cost of the prescription. The Plan reimburses you 100% of Caremark's network retail price minus your applicable co-payment. There may be a significant difference between the price you pay at a non-network pharmacy and the discounted network cost.

To receive your reimbursement, complete a Caremark prescription drug claim form and include your original prescription receipt(s) and mail it to the address on the claim form.

Claim forms are available from Caremark Inc. or the **Retiree web site** at <http://retirees.coned.com>.

How to Obtain Prescription Mail Service Benefits

To obtain prescriptions by mail, follow these steps:

1. Ask your healthcare professional for a prescription for up to a 90-day supply. Please keep in mind that if the prescription may be filled by a generic drug it will provide you with a savings. Your co-payment is listed in the *Schedule of Contributions and Co-Payments* in the back pocket of this booklet.
2. To obtain a maintenance drug you are already taking, ask your healthcare professional for a **new** prescription for a 90-day supply. While waiting for your new prescription, use up any remaining amount. The law requires that pharmacies (including Caremark) dispense the exact quantity prescribed by a doctor. Your doctor must prescribe a 90-day supply for you to receive that quantity.
3. Complete the patient profile/order part of the Caremark order form. Order forms are available to download on the **Retiree web site** at <http://retirees.coned.com>, by calling Caremark at 1-800-601-6364 or by calling Employee Benefits at 1-800-582-5056. Be sure to answer all the questions, include your Social Security number, sign and date the certification section and include a check or major credit card number for your co-payment.

If you are unsure if the drug you are ordering is a name-brand or generic drug, pay the larger amount shown in the *Schedule of Contributions and Co-Payments* in the back pocket of this booklet, and any over-payment will be credited to your account. Caremark will send you a statement on a regular basis which will list your orders, payments and credits.

4. Send your prescription and payment along with a completed patient profile/Caremark order form to the address listed on the form. **Please do not enclose your Caremark prescription card.**

Once your prescription is on file at Caremark, you can order refills by calling Caremark at 1-800-601-6364 or by visiting <http://www.rxrequest.com>. Be prepared to give a major credit card number when you place your refill order.

5. Caremark processes your order and sends your medications by first-class U.S. mail or insured UPS along with reorder instructions for future prescriptions and/or refills. You should allow up to **21 days for delivery**. Overnight delivery is also available for medication at your expense.

If You Need Medication Immediately

If you need medication immediately but will be taking it on a long-term basis, ask your doctor for two prescriptions – the first for a 21-day supply that you can have filled at a local pharmacy with your prescription card and the second for up to a 90-day supply. Send the second prescription to Caremark immediately with your completed order form and payment.

Prescription Drug Exclusions

The following drugs, supplies, and services are not covered under the **Prescription Drug Plan**. As prescription care continues to change, it is not always possible to determine whether a service or supply will be covered. If a service or supply is not specifically listed, it still may not be covered. If you have any questions you should call Caremark before you incur any expense for a service or supply.

- non-legend drugs,
- experimental or unproven drugs or drugs labeled “Caution – limited by federal law to *“investigational use,”*”
- cosmetic drugs,
- over-the-counter medications (except insulin),
- therapeutic devices or appliances, including hypodermic needles and syringes, support garments and other non-medicinal substances (however, the mail-order service does cover needles and syringes used in the treatment of diabetes),
- fertility drugs or test devices,
- immunization agents, biological sera, blood or blood plasma,
- charges for the administration or injection of any drug,

- medication taken by or administered to a patient in a licensed hospital, nursing home or skilled nursing facility that operates a facility for the dispensing of prescription drugs on its premises,
- any other pharmaceutical items not classified as legend drugs,
- levonorgestrel (Norplant),
- topical monoxidil⁷ (Rogaine) for the treatment of alopecia, *or*
- prescriptions which an eligible person is entitled to receive without charge under any workers compensation law, or any municipal, state or federal program.

Caremark may contact your doctor after receiving your prescription to request consideration of an alternative therapy, a preferred drug list product or generic equivalent. Please note that any resultant action will only be taken when it is explicitly authorized by your doctor's office. This action may result in your doctor prescribing a different course of medication, brand name product or generic in place of your original prescription.

If You Have Questions

If you have questions about the *prescription card program* or the *mail-order prescription program*, call **Caremark** at 1-800-601-6364.



⁷ Please note that oral monoxidil is covered.



Claims and Appeals

If you have or your covered dependent has a claim that will not be or was not covered or paid in part or in full, you must bring your claim to the proper fiduciary. If your claim is about eligibility to participate, then the fiduciary is the Plan Administrator. For claims regarding the **Prescription Drug Plan**, the fiduciary is Caremark. If you have a claim against an **HMO**, the **HMO** will tell you who is the fiduciary for the processing of the claim. UnitedHealthcare is the fiduciary for the **Retiree Health Plan**. You must exhaust these claims procedures before you can take legal action.

There are different kinds of claims: *urgent care claims*, *pre-service claims*, *post-service claims*, *concurrent care claims* and *other claims*. Each kind of claim has its own deadline for its appeal and resolution.

Urgent care claims are those claims that require notification and confirmation of coverage prior to receiving medical care and where a delay in treatment could seriously jeopardize your life, health or the ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain.

When you have an *urgent care claim*, you or your representative must notify, in writing or orally, the applicable fiduciary. Once you have properly notified the fiduciary of your *urgent care claim*, the fiduciary will notify you or your representative whether your *urgent care claim* will be covered and/or paid within 72 hours of receipt of your properly filed claim. You must file a proper claim or there may be a delay in the determination by the fiduciary. The fiduciary will notify you of an improper filing or if more information is needed within 24 hours after your *urgent care claim* is received. You have 48 hours to provide the requested information. You then will be notified of a determination within 48 hours after the receipt of the requested information or the end of the time period you were given to provide the additional information (if the information is not received within that time). The fiduciary will notify you of a denial orally, in writing or electronically. Written or electronic confirmation will follow within three days.



A *pre-service claim* is a claim that needs prior notification before the claim will be covered and paid in full or in part. A *pre-service claim* includes a notification to avoid a penalty. The initial determination for a *pre-service claim* will be made within 15 days of receipt of the claim. If you file a *pre-service claim* improperly, the fiduciary will notify you within five days after the claim is received of the improper filing and how to correct it. If additional information is needed to process the *pre-service claim*, the fiduciary will notify you within 15 days after the claim is received of the information needed. The fiduciary may request a one-time extension of up to 15 days. Once notified of the extension, you then have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of a determination within 15 days. If the needed information is not provided within the 45-day period, the claim will be denied.

A *post-service claim* is for payment of medical care that has already been received. If your *post-service claim* is denied, you will be notified within 30 days. If additional information is needed or the claim was filed improperly, the fiduciary will notify you within the 30-day period. The fiduciary may also request a one-time extension of up to 15 days. If the extension of time is necessary due to your failure to submit necessary information, you have at least 45 days to provide the requested information. If all of the needed information is received within the 45-day time frame and the claim is denied, the fiduciary will notify you within 15 days. If you do not provide the needed information within the 45-day period, the claim will be denied.

A *concurrent care claim* is for ongoing treatment. This claim covers either an ongoing treatment for a period of time or a number of treatments. A *concurrent care claim* is for previously approved benefits that the fiduciary has decided to terminate or reduce. If it is a claim seeking to extend ongoing urgent health care, you will be notified whether the claim has been approved or denied within 24 hours after receiving it. If your request is for non-urgent care, your request will be considered a new claim and decided according to post-service or pre-service time frames.

In all cases, the denial will explain the reason for the denial, refer to the part of the Plan/Program on which the denial is based and provide the claim appeal procedures.

Appeals

UnitedHealthcare provides for two levels of internal appeals of adverse determinations. If you are appealing a denial of a UnitedHealthcare adverse determination, you have up to 180 days to bring your first appeal request. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal must be submitted to UnitedHealthcare within 60 days from receipt of the first level appeal decision.

A first level of appeal of a *pre-service claim* to UnitedHealthcare will be acted upon within 15 days from the receipt of your request for a first level appeal. The second level appeal of a *pre-service claim* to UnitedHealthcare will be decided within 15 days from receipt of a request for a second level appeal.

If you are appealing a *post-service claim* to UnitedHealthcare, the first level of appeal will be determined within 30 days from receipt of your request for an appeal. A second level appeal of a *post-service claim* will be determined within 30 days from receipt of a request for review of the first level appeal decision.

Determination and notification for an *urgent care claim* appeal will be provided within the 72-hour period following the receipt of your request for an appeal. The appeal does not need to be in writing. You or your representative should call UnitedHealthcare as soon as possible.

If you are appealing a determination of a fiduciary who is not UnitedHealthcare and that fiduciary provides one level of appeal, then in that case:

- for *pre-service claims* the fiduciary will notify you of its determination within 30 days of receipt of your properly filed request for an appeal, *and*
- for *post-service claims* the fiduciary will notify you of its determination within 60 days of receipt of your properly filed request for an appeal.

If the fiduciary provides two internal appeals of an adverse benefit determination, the same deadlines that apply to UnitedHealthcare will apply.

Adverse Decision Notification Requirements

The fiduciary will provide you with a specific reason for its denial, including identification and access to any guidelines or rules used in making the adverse determination. Denials based on an experimental, unproven or investigational treatment will include the clinical judgment involved in applying the terms of the Plan to your circumstances or a statement that an explanation will be provided free of charge upon request.

The Plan will provide you with access to all documents, records and other information relevant to the benefit determination or state that the information is available free of charge upon request. The fiduciary will disclose the name of medical professionals consulted as part of the claims procedure. If an adverse benefit determination is made in an *urgent care claim*, you will receive a description of the expedited review process.

The appeal of an adverse determination of a health care claim will be made by a medical expert fiduciary who is not a subordinate of the initial decision maker. The medical expert fiduciary will accept new evidence or information and the claim will be reviewed again. The fiduciary will consult with an appropriate medical expert fiduciary in deciding appealed claims involving medical judgment.



Other Claim Matters

For other claim matters, if the claim is wholly or partially denied, the fiduciary will notify you no later than 90 days after the receipt of the claim.

The fiduciary will notify you in writing within the first 90 day period if an extension is needed to process the claim because of special circumstances. The extension of time may not exceed an additional 90-day period.

If the fiduciary makes an adverse benefit determination, the notice of the adverse decision will provide:

- the specific reason(s) for the adverse determination,
- the specific plan provision(s) on which the decision is based,
- a description of additional information necessary, *and*
- a description of the review and appeal procedures, including appeal time limits.

If you want to appeal the adverse determination, a written request must be submitted to the fiduciary within 60 days after receiving written notice of the denial of the claim. The written statement must include a request for an appeal detailing the need for an initial review, any facts in support of the appeal, and any issues or comments which you deem relevant to the appeal.

The fiduciary must act within 60 days after the later of receipt of your request for an appeal or receipt of any additional materials. If an extension of time is needed to process the appeal, within the first 60-day period, the fiduciary will notify, in writing, the need for an extension. The extension may not exceed an additional 60-days.

A full and fair review will be made for each appeal. You may be required to submit, within 60 days after receiving a written notice, additional facts, documents or other evidence necessary or advisable for the review.

The fiduciary will make an independent determination of your benefits under the Plan. Appeals for benefits are final and conclusive.

Coordination of Benefits (COB) with Other Plans

The entire *Retiree Health Program* applies a coordination of benefits provision (COB) and asserts its full subrogation rights.

The *Retiree Health Program* coordinates benefits with other insured and self-insured group health plans, closed panel or other forms of group type insured and self-insured coverage, government plans (other than Medicaid), medical care components of group long-term care contracts, and motor vehicle coverage, as permitted by law.

In accordance with the COB provisions, the *Retiree Health Program* may reimburse you or your covered dependent for up to a total of, but no more than, 100% of reasonable and customary charges for necessary services, as determined by the applicable plan. Depending upon which plan pays first, the *Retiree Health Program* may reduce the amount of benefits it provides to you. In the event a plan has a COB provision that is inconsistent with this *Retiree Health Program*, the *Retiree Health Program's* coordination provision will be deemed operative.

If the other plan does not have a similar coordination of benefits provision, the other plan pays first, regardless of these rules.

In general, the plan that pays first is the primary plan, and the plan that pays after the primary plan is the secondary plan. When the *Retiree Health Program* is the primary plan, benefits are determined before another plan's coverage. When the *Retiree Health Program* is the secondary plan, benefits are determined after another plan and may be reduced.

When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and benefits will be paid. An expense or service not covered by any plan is not an allowable expense. More details on *Coordination of Benefit* rules are included in the Plan document.



Dependent Rule: If a plan covers you as an employee, member, subscriber, or retiree, then that plan is primary. For example, if the *Retiree Health Program* covers your spouse as your dependent but your spouse is actively working and covered as an active employee under another plan, then your spouse's plan is the primary plan for your spouse's medical expenses.



There is a special exception to the dependent rule. If you are Medicare-eligible and Medicare is secondary to the plan covering you as a dependent, and Medicare is primary to the plan covering you as a retiree, then the order of benefits is reversed. In this case, the plan covering you as a retiree is secondary and the plan covering you as a dependent is primary.

Birthday Rule: The birthday rule applies to a dependent child covered under both parents' plan. The birthday rule provides:

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

The birthday rule applies unless there is a court decree.

Court Decree Rule: If there is a court decree, benefits are paid first according to the specific terms of the court decree.



Active or Inactive Rule: The plan that covers you or your covered dependent as an active or inactive employee is the primary plan.

Continuation Coverage Rule: If a person receives continued coverage under federal or state law (for example, COBRA continuation coverage) and also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

If the other plan does not have this rule, and as a result the plans do not agree on the order of benefits, this rule is ignored. If none of the rules above determines which plan pays first, the primary plan is the plan that has covered you or your covered dependent for a longer period of time.

Refund of Overpayments and Subrogation

Overpayments: You must refund any overpayments (payments exceeding the allowable benefits) to the *Retiree Health Program*. If the *Retiree Health Program* pays expenses incurred on account of you or your dependent, you or any person or organization that was paid must refund the overpayment if all or some of those expenses were either not paid, exceeded the allowable benefits, or legally did not have to be paid.

The amount of the overpayment equals the amount paid in excess of the amount that should have been paid under the *Retiree Health Program*. If the overpayment is due from a third party, you or your covered dependent must agree to assist in obtaining the over-payment when requested. If you or your covered dependent do not promptly repay the full amount of the overpayment, the *Retiree Health Program* may reduce the amount of any future benefits that are payable under the *Retiree Health Program*. The reductions will equal the amount of the required overpayment.

Subrogation: The *Retiree Health Program* will be subrogated and succeed to you or your covered dependent (or, in the event of your death or incapacity, your lawful beneficiary or estate) under any theory of right of recovery against a third party. The *Retiree Health Program* may use the right of subrogation to the extent that the amount received through a third-party settlement or satisfied judgment is identified as amounts paid or incurred by the *Retiree Health Program* for the same medical services and benefits. As a condition of participation in the *Retiree Health Program*, you and your covered dependent consent and agree that the *Retiree Health Program*, in its sole discretion, may exercise this right when requested.

In the event of any payment under the *Retiree Health Program*, through its Plan Administrator, or fiduciary, the *Retiree Health Program* shall be subrogated to all the rights of recovery of you or your covered dependent. You or your covered dependent will execute all papers required and do everything to secure documents necessary to enable the *Retiree Health Program* to bring suit in your name or the name of your covered dependent. If you or your covered dependent has a claim against another person or third party for payment of medical or other charges, the *Retiree Health Program* will be subrogated to all rights you or your covered dependent may have against that other person or third party and will be entitled to reimbursement.

You or your covered dependent must:

- assign or subrogate to the *Retiree Health Program* rights to recovery when this provision applies,
- acknowledge that the *Retiree Health Program's* rights will be considered as the first priority claim against third parties, to be paid before any other claims are paid regardless whether or not you or your covered dependent is or has fully recovered,
- authorize the *Retiree Health Program* to sue, compromise and settle in your name or the name of your covered dependent the amount of medical or other benefits paid and expenses incurred by the *Retiree Health Program*,
- reimburse payment to the *Retiree Health Program* made from the other person, the other person's insurer or the third party, the amount of medical or other benefits paid and expenses incurred by the *Retiree Health Program*,
- notify the *Retiree Health Program* in writing of any proposed settlement and obtain the *Retiree Health Program's* written consent before signing any release or agreeing to any settlement,
- do nothing to prejudice the rights of the *Retiree Health Program* under this provision, either before or after the need for services or benefits,
- allow the *Retiree Health Program* to collect from the proceeds of any full or partial payment (whether or not you or your covered dependent has been fully compensated) your legal representative may obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided,
- hold in trust for the benefit of the *Retiree Health Program* under these subrogation provisions any proceeds of settlement or judgment,
- authorize the *Retiree Health Program* to recover reasonable attorney fees incurred in collecting proceeds held by you or your covered dependent, *and*
- execute and deliver documents (including a written confirmation of assignment and consent to release medical records), and provide help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested.



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

The *Retiree Health Program* will not offset the reimbursement for you or your covered dependent's legal costs attributable to recovery from a third party. The *Retiree Health Program* has the right to full subrogation and reimbursement of any and all amounts paid by the *Retiree Health Program*, to or on behalf of, you or your covered dependent. You or your covered dependent will be responsible for all expenses of recovery from third parties for any sum of money received from a third party in connection with an accident. These expenses include, but are not limited to, all attorneys' fees. Fees and expenses shall not reduce the amount of reimbursement to the *Retiree Health Program*. You or your covered dependent will reimburse:

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

Retiree Health Program Costs

Participant Contributions

Retirees, surviving spouses and other participants currently make monthly contributions and pay deductibles, co-payments and out-of-pocket limits towards the cost of the *Retiree Health Program*.

Monthly contributions, deductibles, co-payments and out-of-pocket limits are subject to periodic adjustments based on the expected claims cost, administrative expenses, the amount the company and each Employer elects to contribute, and other factors. The company notifies retirees and other participants whenever an adjustment is required. Contributions and co-payments currently required under the *Retiree Health Program* are shown in the *Schedule of Contributions and Co-Payments* in the back pocket of this booklet. A new schedule is sent to you whenever contributions, deductibles, co-payments or out-of-pocket limits change.

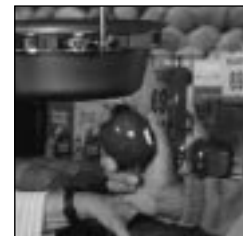
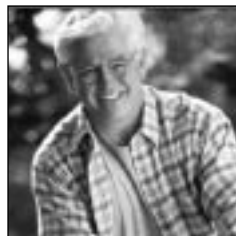
The company deducts retirees' contributions for coverage from their monthly pension benefit checks. If you are not receiving a pension, payments to the Program are made quarterly by sending a check to Employee Benefits.

Disabled Retirees/ Deferred Pension

If you leave the company due to a disability and defer receiving a pension benefit, you must pay your required contribution for the *Retiree Health Program* directly to Con Edison on a quarterly basis.

Medicare-eligible Retirees

If you're eligible for Medicare coverage, your contribution is lower than the contribution for Plan participants who are non-Medicare-eligible because Medicare pays a significant part of your medical expenses.



Company Contributions

Participating retirees, surviving spouses and other participants are responsible for the full cost of the *Retiree Health Program* except to the extent that Con Edison elects to pay a part of the cost. Although Con Edison currently sponsors the *Retiree Health Program*, the information in this summary plan description does not alter the company's rights to change or terminate the Program at any time due to changes in laws governing employee benefit plans, the requirements of the Internal Revenue Code, Employee Retirement Income Security Act, or for any other reason and at any time. The company is not obligated to contribute to any fixed amount or percentage of Program costs.

Effective as of January 2001, the company decided that it will limit the amount of any contribution it makes toward future health care and prescription drug plan costs. From 2002 to 2007, there will be a transition period. During this period, the company may contribute up to approximately 80% of health care costs. Retirees will pay for the remaining Program costs above any company contribution. Each year, beginning in 2008, if the company decides to contribute to the *Retiree Health Program*, the maximum amount will be the previous year's contribution, plus a cost of living adjustment. The cost of living adjustment may be up to the change in the prior year's Consumer Price Index (CPI). Therefore, if the Program costs are projected to increase above the Cost of Living Adjustment, the company's contribution will not be enough to cover the rise in costs, and your monthly contribution will be increased.



If You Have Questions

To get answers to your questions about the *Retiree Health Program*:

Call UnitedHealthcare at 1-800-638-5199 for questions about hospital, medical and vision care.

Call Caremark at 1-800-601-6364 for questions about the prescription card or mail-order Programs.

Call your HMO for any questions about coverage:

- Blue Cross/Blue Shield

Under age 65	1-800-955-3589
Medicare-eligible	1-800-633-6808
- HIP – Florida

New York	1-800-447-8255
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- Humana – Orlando, Florida 1-800-521-4882
- Oxford Health Plans 1-800-444-6222
- U.S. Healthcare 1-800-323-9930



If you have more questions about the **Retiree Health Plan** or your **HMO** that are not answered in this booklet, you can call Employee Benefits at 1-800-582-5056, Monday through Friday, from 9 a.m. to 4 p.m.



When Coverage Ends

Coverage ends:

- on the last day of the month when you or your surviving spouse voluntarily cancel coverage in writing,
- when your spouse or dependent child no longer is an eligible dependent,
- if you, your surviving spouse, or covered dependent stop paying your required monthly contribution,
- fraud, misrepresentation, or false information,
- if the Program is terminated or is replaced by another group health coverage,
- if coverage for spouses, surviving spouses or dependent children are terminated under the Program *or*
- your coverage will also end even if you are hospitalized or receiving medical treatment on the date that coverage would otherwise end.

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

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



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

A child of a retiree who is born or placed for adoption with your spouse during a period of COBRA coverage will be eligible by notifying the Plan Administrator of the birth or adoption.

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

COBRA coverage does not end if your spouse or dependent children become covered under a group health plan containing a pre-existing condition rule. In this case, the affected person could continue Con Edison retiree medical coverage to the end of the 36-month period only for care for the pre-existing condition.

You are entitled to a certificate that will show evidence of your prior health coverage since July 1, 1996. You can use this certificate to help obtain coverage without a pre-existing condition exclusion.



Notice of Privacy Standards Under HIPAA

Effective April 14, 2003, the *Retiree Health Program* will use protected health information (PHI) only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the *Retiree Health Program* will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment means activities undertaken by the *Retiree Health Program* to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to you or your covered dependent to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost-sharing amounts (for example, cost of a benefit, Plan maximums and co-payments as determined for a claim),
- coordination of benefits,
- adjudication of health benefit claims (including appeals and other payment disputes),
- subrogation of health benefit claims,
- establishing participant contributions,
- risk adjusting amounts due based on enrollee health status and demographic characteristics,



- billing, collection activities and related health care data processing,
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
- reviews or reviews of appropriateness of care or justification of charges,
- utilization review, including pre-certification, preauthorization, concurrent review and retrospective review, *and*
- reimbursement to the *Retiree Health Program*.

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

- quality assessment,
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions,
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities,
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance),
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance Programs,



- business planning and development, such as conducting cost-management and planning related analyses to managing and operating the *Retiree Health Program*, including formulary development and administration, development or improvement of payment methods or coverage policies,
- business management and general administrative activities of the *Retiree Health Program*, including, but not limited to:
 - management activities relating to implementation of and compliance with HIPAA’s administrative simplification requirements, or customer service, including the provision of data analyses for policy-holders, plan sponsors or other customers,
 - resolution of internal grievances, *and*
 - due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The *Retiree Health Program* will disclose PHI to all service providers for example, Caremark, UnitedHealthcare and HMOs, Medicare, Social Security Administration, state and federal regulatory government agencies, the Employers, the *Consolidated Edison Retirement Plan*, for the purposes related to treatment, payment or operation of activities of these plans.

The service providers and CECONY have provided a certification that the Plan documents have been amended to incorporate the necessary and required HIPAA privacy provision.



The Plan Sponsor and each Employer agrees to:

- not use or further disclose PHI other than as permitted or required by the *Retiree Health Program* document or as required by law,
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Program agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI,
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual,
- report to the Program any PHI use or disclosure that is inconsistent with the uses or disclosures provided for which it becomes aware,
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
- make available the information required to provide an accounting of disclosures,
- make internal practices, books and records relating to the use and disclosure of PHI received from the *Retiree Health Program* available to the HHS Secretary for the purposes of determining the *Retiree Health Program's* compliance with HIPAA, *and*
- if feasible, return or destroy all PHI received from the *Retiree Health Program* that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI: the staff members designated by the Privacy Officer. As of April 14, 2003, the Privacy Officer is Hector J. Reyes.

Plan Information – The Retiree Health Program

The following information is provided to meet the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The *Retiree Health Program* includes the **Retiree Health Plan, HMOs and Prescription Drug Plan.**

Funding

The *Retiree Health Program* is currently funded through contributions by participants in the Program and by the company. These contributions are made to a special sub-account in the trust fund under the company's pension plan and two trust funds established by the company. The *Retiree Health Program* is a employee welfare benefit plan under ERISA. The two trust funds are intended to qualify as Voluntary Employees' Beneficiary Associations (VEBAs), exempt from federal income taxes under Section 501(c) (9) of the Internal Revenue Code of 1986, as amended.

Name and Address of Employer/Plan Sponsor

Consolidated Edison Company of New York, Inc.
4 Irving Place
New York, NY 10003

Plan Identification

The following number identifies the Plans that makes up the *Retiree Health Program*:

The Consolidated Edison Retiree Health Program for Management Employees – Plan Number 553

The Consolidated Edison Retiree Health Program for Weekly Employees – Plan Number 554

Con Edison's Employer Identification Number – 13-5009340



Type of Plan

The *Retiree Health Program* is a welfare benefit plan that provides hospitalization, medical, prescription drug and vision care benefits to eligible retirees, spouses and their dependents.

Type of Administration

Under the **Retiree Health Plan**: Hospital, medical and vision care benefits are self-insured and administered by UnitedHealthcare, P.O. Box 740800, Atlanta, GA 30374-0800.

Under the **HMOs**: Hospital, medical, vision care, prescription drug and preventive care, including dental services, provided by HMOs, are fully insured and administered by each individual HMO.

Under the **Prescription Drug Plan**: Prescription drug benefits are self-insured and administered by Caremark Inc., PO Box 686001, San Antonio, TX 78268-9969.

Plan Administrator and Named Fiduciary

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

Named Fiduciaries for the management and control of the Trust Funds

The Chairman, President and Chief Executive Officer, the Executive Vice President and Chief Financial Officer, and the Chief Accounting Officer of the company.

Each fiduciary within the exercise of his or her delegated authority, has the full and absolute discretion to construe and interpret the terms of the *Retiree Health Program*, determine the validity of charges submitted, if applicable, and, within his or her authority, make final binding determinations concerning the administration and operation of the *Retiree Health Program*.

Trust Fund Trustee

State Street Bank and Trust Company
Master Trust Services
P.O. Box 1992
Boston, MA 02105-1992

The Board of Trustees of Consolidated Edison Company of New York, Inc. has the right to appoint and remove the Trustee. Administrative expenses of the Program and the Trust Fund are paid by the Trust Fund.

Agent for Service of Legal Process

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

Plan Year

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

Plan Document

This booklet describes the main provisions of the *Retiree Health Program*. The official plan documents legally govern the operation of the plans.



Limitation of Action

If you want to bring a legal action against the *Retiree Health Program*, UnitedHealthcare, Caremark or a HMO, you must do so within three years from the expiration of the later of the time period in which a request for reimbursement was submitted or the date you were notified of a final decision or you lose any rights to bring such an action against the Program, UnitedHealthcare, Caremark or a HMO. Denials of claims because of an improper filing are treated as a final decision.

Relationship with Providers

The relationships between UnitedHealthcare and the network providers are solely contractual relationships. The network providers are not agents or employees of UnitedHealthcare. Neither UnitedHealthcare nor the Plan Administrator is liable for any act or omission of any provider.

UnitedHealthcare does not practice medicine. Rather, UnitedHealthcare, on behalf of the company, pays benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare engages in a credentialing process that confirms public information about the providers' licenses and other credentials.

Incentives to Providers

UnitedHealthcare pays network providers through various types of contractual arrangements, some of which may include financial incentives to deliver health care in a cost efficient manner. These financial incentives are not intended to affect your access to health care. If you have questions about whether your network provider's contract includes any financial incentives, you are encouraged to discuss those questions with your provider.

Coverage Provided For Reconstructive Surgery Following Mastectomy

The *Women's Health and Cancer Rights Act* of 1998, a federal law, requires group health care plans to provide coverage for reconstructive surgery and prostheses following mastectomies.

The law also requires participants be notified annually of the benefit provisions under the company's health care plans for reconstructive surgery following a mastectomy. Benefits for a mastectomy include:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses
- treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage is provided in consultation with the attending physician and the patient and is subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about coverage for mastectomies and reconstructive surgery, call your health care provider.

Mother and Newborn Coverage

The *Retiree Health Program* may not restrict benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. After consulting with the mother, the mother's or newborn's attending provider may discharge the mother or her newborn earlier than 48 or 96 hours as applicable. There is no requirement that your provider obtain authorization for prescribing a length of stay not in excess of 48 or 96 hours as applicable.



Determinations of Qualified Medical Child Support Orders

The *Retiree Health Program's* procedures for handling qualified medical support orders are available without charge upon request to the Plan Administrator.

For Questions About Eligibility or Coverage

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

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

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

Future of the Program

The company currently sponsors the *Retiree Health Program* described in this booklet, but reserves the right to change or end the Program at any time or for any reason. In addition, the company reserves the right to determine from time to time the level of contributions required from plan participants for coverage.

Statement of ERISA Rights

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

- Examine, without charge, at the Employee Benefits Department, Room 1100, 4 Irving Place, New York, NY 10003, all plan documents, insurance contracts, and copies of all documents filed with the U.S. Department of Labor, and the Public Disclosure Room of the Pension and Welfare Benefit Administration such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child's support order, you may file suit in federal court.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you must file the claim first with the appropriate fiduciary and exhaust your internal claim's procedures before you may file a suit in court. You must bring an action within the three year time period specified in the *Limitation of Action* section. If it should happen that the Program fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the *Retiree Health Program*, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Administration, U.S. Labor-Management Services Administration, Division of Technical Assistance and Inquiries as listed in your telephone directory or the Department of Labor, 200 Constitution Ave., N.W., Washington D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

If you have more questions about the *Retiree Health Program* that are not answered in this booklet, you can call Employee Benefits at 1-800-582-5056.



The Consolidated Edison Retiree Health Program



Understanding Your
Health Care Benefits

July 2003