FIRST REHAB LIFE®

employer & employee brochure

plan 1

EXCESS MAJOR MEDICAL

for school districts, municipalities and subdivisions that participate in the Empire Plan or an approved similar plan

out-of-network coinsurance benefit

out-of-network deductible reimbursement

annual vision care benefits

in-hospital **private duty nursing**

out-of-network outpatient rehabilitation

nursing home benefit

in-hospital benefit for employees only

AD&D benefit for employees only

40 YEARS 1972–2012

THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA

A.M. Best Rating A- (excellent)

Out-of-Network Coinsurance Benefit

Coinsurance for out-of-network psychiatric expenses is **included** in this benefit.

Your approved plan typically pays 80% of allowed expenses for out-of-network services, which leaves you responsible for coinsurance of 20%. First Rehab Life's coinsurance benefit reimburses the remaining out-of-network coinsurance amount for allowed expenses covered under your approved plan or up to the following annual maximums with family coverage:

Employee	Spouse/Domestic Partner	Dependent Child(ren)
$3,000	$3,000	$3,000

Examples:

Amount charged by provider	Amount allowed (by approved plan)	Your deductible	Balance allowed (by approved plan)	Amount paid by approved plan (80% of balance allowed)	Your balance (20% coinsurance of balance allowed plus other out-of-pocket)	This benefit pays
$2,000	$2,000	$1,000	$1,000	$800	$200	$200
$7,000	$7,000	$0	$7,000	$5,600	$1,400	$1,400

Out-of-Network Deductible Reimbursement

Once you reach a set amount of covered expenses (amount allowed) under your approved or similar plan, this benefit reimburses out-of-network deductibles up to the following maximums on a dollar-for-dollar basis:

	Employee Coverage	with Family Coverage		
	Employee	Spouse/ Domestic Partner	Dependent Child(ren)	Combined Family Max
Amount allowed reaches the following kick-in point	$100	$100	$100	$250
Maximum amount reimbursed	$1,000	$1,000	$1,000	$3,000

Note: Amount for individual reimbursement cannot exceed $1,000

Examples:

Amount charged by provider	Amount allowed (by approved plan)	Your deductible	Balance allowed (by approved plan)	Amount paid by approved plan (80% of balance allowed)	Your balance (20% coinsurance of balance allowed plus other out-of-pocket)	Benefits paid under this policy Reimbursement for	
						Coinsurance	Deductible
$1,500	$1,000	$1,000	$0	$0	$1,500	$0	$1,000
$2,000	$2,000	$1,000	$1,000	$800	$1,200	$200	$1,000
$5,000	$4,000	$1,000	$3,000	$2,400	$2,600*	$600	$1,000

* 20% coinsurance = $600 + $1,000 deductible + $1,000 out-of-pocket for difference between amount charged and amount allowed.
**Amount allowed must be $100 for individual to recover under this example.

In-hospital Private Duty Nursing Benefit

This benefit provides 50% of the Reasonable & Customary (R&C) Charge for a total of 48 hours of private duty nursing while hospitalized.

Out-of-Network Outpatient Rehabilitation Benefit

To qualify for this benefit, you must meet the following criteria:

1. You must have been hospitalized on an inpatient basis; and
2. then transferred to a comprehensive outpatient Rehabilitation Center (regular physical therapy offices do not qualify for this benefit).

Specific areas of outpatient rehabilitation services include:
Occupational therapy, physical therapy, speech therapy, inhalation therapy, psycho-diagnostic evaluation (excluding treatment), coordination of medical services (Medical Social Services), audiological evaluation, and loan of rehabilitation equipment by the Rehabilitation Center's physician.

PLEASE NOTE:

If your rehabilitation service does not meet both criteria, this excess policy still pays based on the out-of-network coinsurance reimbursement benefit (see left for details).

Your approved plan typically pays 50% of the amount allowed for these services. If you meet the above criteria, this benefit pays the remaining percentage on a dollar-for-dollar basis for as long as your approved plan honors your treatment.

Helpful Definitions

Co-payment: This is a set amount you get charged for in-network services.

Coinsurance: This is a percentage of the allowed balance you have to pay for out-of-network services.

Out-of-network Reasonable & Customary (R&C) Charge: R&C is short for Reasonable and Customary Charge. It is the lowest of:
1. the amount charged by the provider,
2. the usual charge by the provider for the same or similar services; or
3. the usual charge by other providers in the same geographic area for the same or similar services.

Reasonable & Customary (R&C) Reimbursement for Out-of-Network Surgical Procedures

This benefit applies to inpatient and outpatient surgical procedures that are performed by an out-of-network physician, have an assigned surgical code from your approved plan, and are declined by your approved plan due to reasonable/customary reasons only. We reimburse the R&C charge for those procedures up to our listed R&C maximums.

Please note: we require a surgical report with an itemized bill and procedure codes; this benefit does not apply to procedures that are cosmetic or not medically necessary.

Nursing Home Benefit

To qualify for this benefit, you must meet the following criteria:
1. You must have been hospitalized for at least 3 days and
2. then transferred to a nursing home (assisted living facilities or rehab facilities do not qualify for this benefit)

Currently, if you are qualified for Medicare, up to 102 days of nursing home care are paid for. If your approved plan has a nursing home benefit, it will kick in on day 103, after Medicare has been exhausted, and may typically run for 30, 60, or 90 days.

Once your approved plan's benefit duration is exhausted, this excess policy pays for up to 30 additional days on a dollar-for-dollar basis. This benefit does not pay during the period of time that your approved plan pays, regardless of benefit level provided by your approved plan.

PLEASE NOTE:

If your approved (or similar) plan does not have a nursing home component, you do not qualify for the 30-day benefit under this excess policy.

Vision Care Benefit

Please see Vision Coverage Summary on Last Page

Special Employee-only Benefits

Hospital Cash Benefit for covered Employees only

This benefit provides **$50 cash benefit per 24-hour period** if you are continuously confined to a hospital and under the care of a doctor. The maximum duration is 26 weeks per calendar year. You must be in the medical/surgical unit of a hospital (rehab, nursing, or other units of a hospital don't qualify for this benefit).

Accidental Death & Dismemberment Benefit for covered Employees only

This benefit pays **$15,000 in the event of accidental death** to your beneficiaries. Accidental dismemberments are covered based on the following benefit schedule:

Both hands or both feet or sight of both eyes	$15,000
One hand or one foot or sight in one eye	$15,000
One hand or one foot	$7,500
Sight in one eye	$7,500

1. HOW CAN I GET A CLAIM FORM?

1. Go to our website: www.firstrehab.com
2. Click on the Insureds' Portal on the left.
3. Select "Services for all other Employee Benefits"
4. Click on the menu "Download Claim Forms"
5. Select your State (NY), Product (Excess Major Medical for medical claims or Vision for Vision claims), Doc Type (Claim Forms), and click submit.
6. The forms will then show below and can be printed.

2. HOW DO I FILL OUT A CLAIM FORM?

- Complete the Insured's portion of the form only
- Attach an itemized bill.
- Attach an Explanation of Benefits (EOB) from your approved plan(s).

3. WHERE DO I SEND A CLAIM?

① Medical Claims:
Send the completed claim form to:
First Rehab Life
Excess Major Medical Claims
600 Northern Blvd.
Great Neck, NY 11021
Fax 516-289-8213
excessmajorclaims@firstrehab.com

YOUR PLAN COORDINATOR IS:

J.J. Stanis and Company, Inc.
377 Oak Street, Suite 406
Garden City, NY 1 1 530
Phone: 877-470-3715
www: jjstanisco.com

Exclusions, Limitations & Conditions

The following co-payments are not covered under this excess policy: copayment for Empire participating providers, copayment for Blue Cross hospital outpatient care, copayment for outpatient care incurred with a network provider, copayment for prescription drug program. This policy provides limited health insurance benefits. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Any expenses not covered by the underlying Empire Plan (or approved similar plan) are not covered under this excess policy.

Please note: The $1,000,000 annual excess major medical expense benefit is still included in this policy. However, due to legislative changes to the insurance market, your approved plan limits have been removed, thus making this benefit no longer applicable.

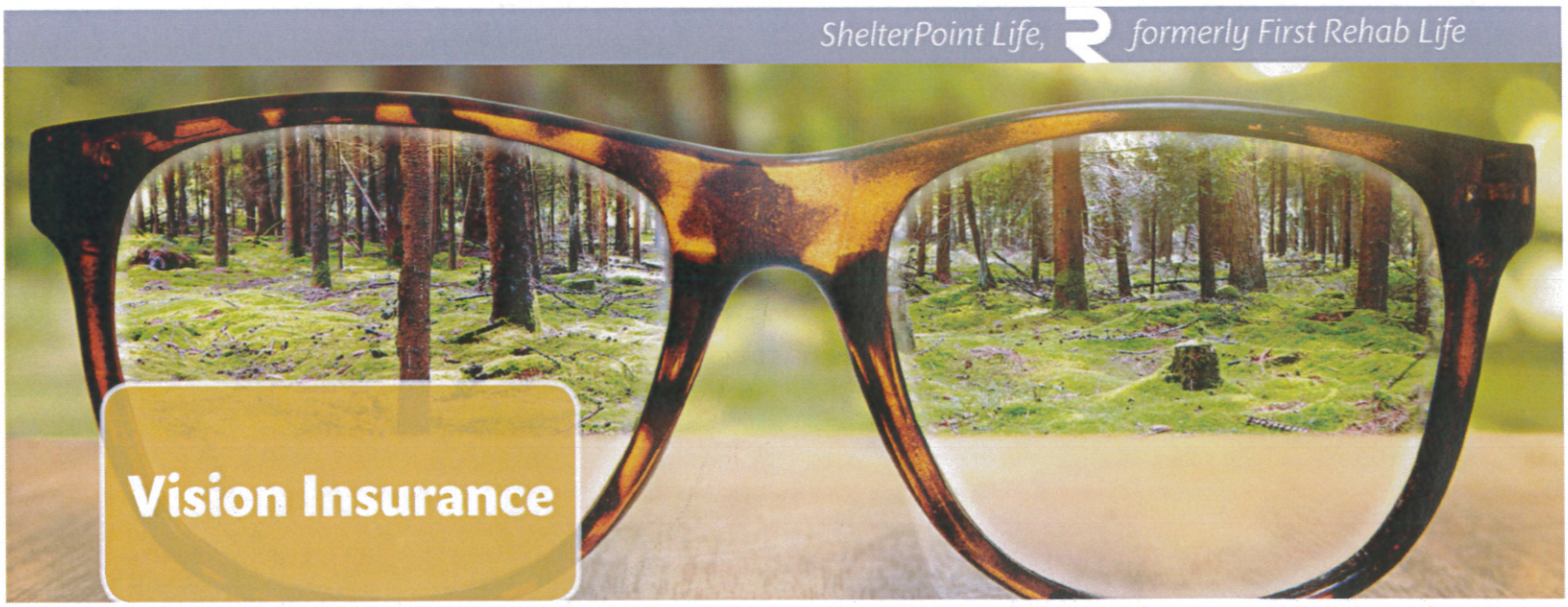
Excess Coverage: The policy pays benefits only after all benefits have been paid from any other group health insurance policies in effect for the covered person and provided by the policyholder. This policy does not cover any expense unless it is also eligible for coverage under any other group health insurance policy in effect for the covered person and provided by the policyholder. All benefits available from underlying policies must be exhausted before coverage is available under this policy. No covered expense will be paid if it may also be paid by any other group health insurance policy in effect for the covered person and provided by the policyholder.

This insurance does not cover the following expenses: 1. treatment by other than a doctor or when not under the care of a doctor, charges by a hospital if confinement is not recommended and approved by a doctor | 2. treatment of injury or sickness for which compensation is provided under any Workers' Compensation Law or Act, mandatory automobile no-fault insurance, or Medicare | 3. services for which benefits are paid or will be paid under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision; services provided in a government owned or operated facility or other locations where care is provided at government expense, unless the covered person is required to pay for such treatment or service in the absence of insurance | 4. dental care, treatment or x-ray except for treatment by a doctor, dentist, or dental surgeon (DDS) within twelve (12) consecutive months following an injury to a jaw or sound natural teeth and except for dental care or treatment necessary due to congenital disease or anomaly | 5. eye refractions, eyeglasses or contact lenses unless otherwise covered; hearing aids or the fitting of such devices | 6. cosmetic surgery. Reconstructive surgery and/or prostheses to correct congenital abnormalities or following medically necessary surgery is not considered cosmetic surgery | 7. care provided to a covered person in a skilled nursing (extended care) facility, unless otherwise covered. A skilled nursing (extended care) facility means an institution or a distinct part thereof that: a. is licensed pursuant to federal, state and local laws; b. is operated mainly for the purpose of providing skilled nursing care to persons recovering from an injury or sickness that required hospital confinement for at least 3 consecutive days; c. is a participating skilled nursing facility of Medicare; d. provides medical care and 24-hour nursing care under the constant supervision of a doctor or RN; e. maintains daily clinical records for each patient and has a doctor available or on call; f. provides suitable methods for dispensing and administering drugs and medicine; g. has transfer arrangements with one or more hospitals and a utilization review plan in effect; and h. has operational policies developed with the advice of, and reviewed by, a professional group including at least one doctor. Skilled nursing (extended care) facility does not include a facility that is, other than incidentally: a. a home for the aged, or b. a place for the treatment of substance abuse or alcoholism | 8. charges in excess of reasonable and customary charges for the diagnosis or treatment of illness or injury, or any other charges which are in excess of reasonable and customary charges | 9. services rendered by a member of the treated person's immediate family | 10. charges resulting from intentionally self-inflicted injury | 11. any service or treatment for which payment is not legally required | 12. treatment for disease, defect, injury or loss caused by war or act of war, declared or not; or by a war-like act in time of peace | 13. treatment of injury or sickness suffered by a covered person while on duty with any military, naval, or air force of any country or international organization | 14. treatment for which any law of the jurisdiction in which the covered person resides prohibits payment | 15. co-payments for the following network options, if underlying primary major medical coverage includes a network: a. treatment by participating providers; b. in-patient or out-patient care in a network hospital; c. out-patient psychiatric care incurred through treatment by a network participating provider; or d. participation in a prescription drug program | 16. with the exception of Rehabilitation Benefits, Section II, Covered Expenses, expenses not eligible for coverage under all underlying insurance then in force for the covered person through the policyholder.

The information in this material is not intended as an offer of coverage ("Invitation to Contract"). It is for illustrative purposes only, providing a general overview of the services described. It is not a contract. Not available in all jurisdictions. Policies are subject to Underwriting approval. All coverage extends up to policy limits. Policies are reviewed annually and may be cancelled for nonpayment. Please refer to the policy for coverage details, a complete listing of covered services, policy provisions, conditions, exclusions, and terms under which the policy may be continued or cancelled. In the event of conflicting information with the policy, the policy will take precedence over what is shown in this material. Every policyholder must cover all eligible full-time employees with a minimum of 50 covered employees at all times. Mktg #XM-B4-NY- P1-ER/EE- Guide- G2a 12/11 | Policy Form# XGMMP-NY 01/01, XGMM-1-NY

SHELTERPOINT

www.shelterpoint.com | 800.365.4999



Vision Claims Guide

If you choose to take advantage of the in-network savings, you can locate NVA Vision network providers on their website: **www.e-nva.com**

1. How do I submit a claim?

In-network benefits:
No claim forms are needed if you choose an NVA network provider! Simply provide the vision provider's office with the member ID number and/or name and date of birth of any covered dependent needing services. The vision provider's office will verify your eligibility for services. **NVA providers do not require ID cards.** However, if you would like an ID card, please register on the NVA web portal at: **www.e-nva.com**
After registering, ID cards will be available for print.

Out-of-network benefits:
You have the freedom to choose any licensed eye care provider. If a non-participating provider is chosen, you will be responsible for 100% of the cost at the time of service and may then submit a claim for reimbursement either **online at www.e-nva.com** or by mail to our dedicated Vision Claim Administrator:

NVA
National Vision Administrators, L.L.C.

NVA
Attn: ShelterPoint
P.O. Box 2187
Clifton, NJ 07015

2. How can I check the status of my claim?

- Visit the member portal at: **www.e-nva.com**
- Call the dedicated toll-free member services telephone number: **877-241-7124**

Optional NVA Provider Network Enhancements		
Policyholder: XGNY1113 - Franklin Square U.F.S.D.		
Examination	**Once every 12 months[1]**	
		Covered 100%
Lenses	**Once every 12 months[1]**	
	Single vision	**Covered 100%**
	Bifocal vision	**Covered 100%**
	Intermediate vision	**Covered 100% after $30 copay**
	Trifocal	**Covered 100%**
	Lenticular	**Covered 100%**
Lens Options	**Once every 12 months[1]**	
	Scratch resistant coating	**Covered 100% after $10 copay[2]**
	Fashion/gradient tint	**Covered 100%**
	Solid tint	**Covered 100%**
	Glass photogrey single vision lens	**Covered 100% after $15 copay[2]**
	Glass photogrey bifocal and trifocal lens	**Covered 100% after $20 copay[2]**
	Ultraviolet (UV) coating	**Covered 100% after $12 copay[2]**
	Standard anti-reflective (AR) coating	**Covered 100% after $35 copay[2]**
	Premium anti-reflective (AR) coating	**Covered 100% after $48 copay[2]**
	Ultra anti-reflective (AR) coating	**Covered 100% after $60 copay[2]**
	Oversized	**Covered 100%**
	Blended segment	**Covered 100% after $20 copay[2]**
	Standard plastic photosensitive (Transitions) lenses	**Covered 100% after $65 copay[2]**
	High index	**Covered 100% after $55 copay[2]**
	Polarized lenses	**Covered 100% after $75 copay[2]**
	Polycarbonate lenses	**Covered 100% after $20 copay[3]**
	Standard progressive lenses	**Covered 100% after $50 copay[2]**
	Premium progressive lenses	**Covered 100% after $85 copay[2]**
Frames	**Once every 12 months[1]**	
	Frame allowance	**$120 retail allowance[6] (20% overage discount)**
Contacts	**Once every 12 months[1]**	
In lieu of eyeglasses	Maximum allowance for conventional lenses	**$120 retail allowance [4] (15% overage discount)**
	Maximum allowance for disposable lenses	**$120 retail allowance [4] (10% overage discount)**
	Medically necessary contact lenses[5]	**Covered 100%**
	Evaluation, fitting, and follow-up care - standard lens	**Covered 100% after: $20 copay (daily wear lenses)[7]**
		Covered 100% after: $30 copay (ext. wear lenses) [7]
	Evaluation, fitting, and follow-up care - specialty lens	**Covered 100% after $50 copay[7]**
Indemnity Reimbursements		
Examination	**Once every 12 months[1]**	
		Up to $28
Lenses	**Once every 12 months[1]**	
	Single vision	**Up to $26**
	Bifocal vision	**Up to $40**
	Intermediate vision	**Up to $40**
	Trifocal	**Up to $52**
	Lenticular	**Up to $52**
Frames	**Once every 12 months[1]**	
	Frame allowance	**Up to $27**
Contacts	**Once every 12 months[1]**	
In lieu of eyeglasses	Maximum allowance for lenses	**Up to $60**

[1] *Benefit year is based on member's last date of service.*

[2]Actual discounted amounts may vary.

[3]Prior authorization required. Polycarbonate lenses are covered in full for:
Dependent children to age 26, monocular patient, and patients with prescription +/- 6.00 diopters or greater.
All others (Polycarbonate SV discounted to $25 & Polycarbonate Bi/Trif discounted to $30)

[4]Does not apply at Contact Fill or Cole corporate locations (if applicable) and where prohibited by law. Prohibited by some manufacturers.

[5]Prior authorization required.

[6]Does not apply for certain proprietary frame brands and where prohibited by law.

[7]Only covered if member chooses contact lenses.