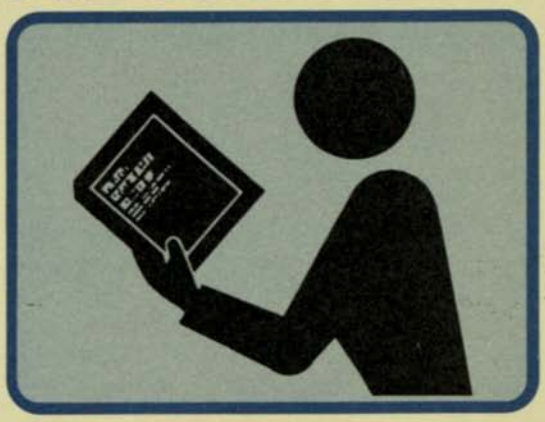
100 E 42nd ST.

PERSONNEL POLICIES & PRACTICES



No section of this guidebook for salaried employees shall constitute either an express or implied contract of employment.

POLICIES & PRACTICES

Personnel policies & practices

Section Page

We're glad you're here

We've designed the employee guide to provide you with a single source of information about your Company, how it operates, what you can expect from us and what we expect of you. Because our policies reflect a living and growing company, they are improved and updated from time to time.

The employee guide also describes the Company benefit plans. We regularly compare these plans against those of leading companies to keep our program up-to-date.

The guide will be useful to our long-term people as well as to newcomers. We'll keep you informed of any policy changes and benefit improvements by issuing new sections for your binders.

Please review the material in your employee guide carefully. Should you have any questions, your supervisor will be glad to answer them for you.

NORTH AMERICAN PHILIPS CORPORATION

North American Philips Corporation

. . . ranks in the top 150 on the "Fortune 500" list of largest U.S. industrial companies. We're a multi-market company, listed on the New York Stock Exchange, with sales of over $3.5 billion. We employ about 50,000 people in more than 30 major divisions and subsidiaries throughout the United States.

North American Philips traces its origins to N.V. Philips of The Netherlands, one of the world's largest industrial organizations. During World War II, N.V. Philips sought to protect certain of its overseas assets from German takeover and established what is known today as the U.S. Philips Trust. Currently, the Trust holds approximately 62% of North American Philips' stock. Our relationship with N.V. Philips provides us with access to a wide range of products, technical know-how and extensive research and development activities.

Our operations concentrate primarily in the following areas:

Consumer Products and Services: Television sets, television picture tubes, videodisc players, stereos, and radios; electric razors and other personal care products; coffee makers and other home appliances; brush products, musical instruments, quality furniture, lighting and transportation.

Electrical/Electronic Components: Fluorescent lamp ballasts and other lighting components; resistors, precision control components, indicator lights and other electrical and electro-mechanical devices; capacitors, magnetron tubes for microwave ovens and other passive and active components; hermetic seals, tungsten products and other materials.

Professional Equipment: Medical diagnostic imaging and therapy systems, analytical X-ray instrumentation, cable television systems, and government and industrial electronic systems.

Equal opportunity

Our company seeks employees of the highest quality.

It is our policy to recruit, hire, train and promote in all job classifications without regard to age, race, color, religion, sex, national origin or physical handicap.

Employees will be paid fairly in proportion to their efforts and contribution to the success of the business, and in accordance with prevailing rates in respective employment locations.

Employees will be promoted whenever practicable from within the corporate structure and on the basis of merit.

We are an equal opportunity employer.

Working together

The kind of Company we are depends upon the kind of people we are and how we work with each other.

In a very real sense, our profitability, vitality, competitive effectiveness and growth potential depend on **you** — on your motivation, your development and your teamwork.

Teamwork is defined by Webster's as "work done by a number of associates each doing a part but all subordinating personal prominence to the efficiency of the whole."

We earnestly believe in teamwork at this company. And whenever people work as a team, there is a need for recognized ground rules. These rules assure our continuity of effort and equitable treatment of all personnel.

It follows, therefore, that your awareness and support of the following ground rules will lead to your continued growth as well as the growth of our business team.

As a new employee

Here are some basics you should know about your job:

Hours of Work

Basic working hours are from 9:00 a.m. to 5:00 p.m. Monday through Friday unless otherwise indicated. You are entitled to one hour for lunch, normally from 12:30 to 1:30 p.m.

Time Cards

The company is required by law to keep accurate records of the hours worked and the money paid to all non-exempt employees. If you are a non-exempt employee, you are required to record the number of hours you have worked on your time card. Time cards must be completed on a daily basis and must be approved by your supervisor on Friday of each week for submission to the Payroll Department.

Probation

During your initial 90 days of employment, you have an opportunity to become familiar with the Company and what it expects from you. At the same time, we hope you will be evaluating what you can expect from the Company. This represents a trial period during which you and the Company decide whether your efforts here will be mutually rewarding.

Attendance & Punctuality

Regardless of what position you hold, you were carefully selected for that position. Thus, your punctuality and regular attendance are essential for efficient operations.

Repeated lateness will affect your job, causing undesirable results in the performance of your department's work.

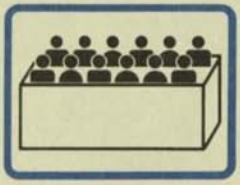
If you know in advance that you must be late or absent, please advise your supervisor. If you are unexpectedly absent, notify your supervisor by telephone as soon as possible.

Incidental absences

Your absence from work for personal or other reasons may be necessary from time to time. In recognition of this, the Company provides time-off with pay for certain kinds of absences. To be eligible, you must be a full-time salaried employee and have completed your 90 day probation period.

- **Illness**
  If you are absent from your job as a result of illness, you must notify your supervisor at the start of each day on which you are out.

- **Personal Emergencies**
  On occasion, personal emergencies may require time-off during the normal work week. If you have such an emergency, be sure to contact your immediate supervisor at the earliest possible moment.



- **Jury Duty**
  Your Company encourages you to accept your responsibility as a citizen. Therefore, if you should receive a "Juror's Summons," notify your supervisor and the Personnel Department immediately. When required, you will be granted time-off to serve on jury duty. So that this will not result in a financial burden, the Company will reimburse you for time lost on the job. You will receive the difference between jury duty pay and your regular salary.

- **Military Leave (short term)**
  If you are in an organized reserve unit and must fulfill two weeks' active duty, you will receive the difference between your service pay and regular salary while on reserve duty. As soon as you are notified of training dates, furnish copies of your orders to your supervisor and to the Personnel Department.

- **Death in Family**
  If you suffer a death in your immediate family (mother, father, wife, husband, daughter, son, sister, brother, mother-in-law, father-in-law, grandmother, grandfather, step-mother or step-father), you will be permitted three days off at your regular rate of pay, including the day of the funeral. **Notify your supervisor as soon as possible.** The Personnel Department must approve all requests for **extended** funeral leaves.

Special leaves of absence

Maternity Leave

Leaves of absence for childbirth will be granted. You must notify the Personnel Department as soon as your doctor confirms that you are pregnant. Personnel will discuss your continuance on the job during pregnancy and every reasonable effort will be made to accommodate you. For health reasons, your return to work after childbirth must first be certified in writing by your physician.

Extended Disability

If you are absent for more than five consecutive days, your supervisor must notify the Personnel Department of your absence not later than the 6th day. At this time, the Personnel Department will send you the appropriate forms for your completion and return. In the case of prolonged absence, the Personnel Department will have the authority to withhold mailing your paycheck in the event that you have not completed and returned the "Notice and Proof of Claim For Disability Benefits."

If you have a problem

When a team of people works together over a period of time, personal problems occasionally arise. Differences with co-workers may develop, you may have a gripe about working conditions, or you may have questions about promotions, salaries, or interpretation of company policies and practices. Whatever the problem might be, the solution lies in discussing it.

The first step is to arrange a sincere and frank talk with your supervisor. Often this can bring to light the simplest, quickest, and most satisfactory solution. In addition to your supervisor, the Personnel Department is always available to assist you in any way possible.

If you should leave the Company

Sometimes people leave, for a wide variety of valid reasons. In any case, you will be asked before your stay here is terminated to stop in at the Personnel Department to go over questions you may have about your benefits, your pay, etc. We hope you will frankly discuss your reasons for leaving at this time. We would like to hear your suggestions.

Your pay and your progress

Paychecks

You are paid by check 24 times a year, on the 15th and the last day of the month.

If the regular payday should fall on a weekend or holiday, you will be paid on the last working day of the pay period. If the payday falls within your vacation, you must advise the Personnel Department in writing at least two weeks in advance if you wish to receive your paycheck before you leave. If you have any questions regarding deductions, please see your supervisor.

Job Classification

Under the Fair Labor Standards Act, positions are classified as "exempt" (not eligible for overtime) and "non-exempt" (eligible for overtime). If you have any questions regarding your classification, please see your supervisor.

Overtime Payments

If you are eligible for overtime, you will be paid time-and-a-half for all hours worked in excess of eight hours in one day. You will also be paid time-and-a-half for Saturday work. Sundays and holidays are compensated at a double-time rate.

Supper Money

If you work a minimum of two hours beyond your scheduled working day, you will be paid a supper money allowance of $3.50. To apply for supper money, complete a petty cash voucher, have it approved by your department head and present it to the cashier in Payroll with the corresponding time card.

Job Progress

You are paid in direct proportion to your individual efforts and the contributions of your position toward the success of our business. This is the basis of our merit pay system which, we believe, encourages outstanding performance. The system allows you to directly influence the size of your paycheck through your performance on the job.

Your Future Here

We make it a policy to promote from within wherever possible. As with raises, we feel promotions must be be earned rather than taken for granted. They are made on the basis of all-round ability. When two or more employees are equal in every way for a promotion or a new job, then service with the company becomes a factor in management's decision.

Your future is up to you. If you want to advance, the best way is to perform your present job as well as you can.

Company facilities

Medical Facilities

In the event of a medical emergency, the Company has made arrangements to provide complete medical care. First aid supplies and trained personnel are available through the Personnel Department. In a medical emergency, employees **at the 42nd Street office only** should dial 243 for assistance.

Coffee

Between the hours of 9:00 a.m. and 10:30 a.m., coffee is available for all employees. Coffee making machines are conveniently located on each of our floors.

Office Security

The Company does everything possible to prevent thievery, but it is impossible to eliminate completely. Unfortunately, we cannot be responsible for personal belongings. Therefore, we urge you to keep such items as handbags, wallets, checks and cash out of sight, and take them with you when you leave your work area.

Good Housekeeping

We spend a considerable amount of money maintaining our premises. A clean and orderly appearance makes for more pleasant working conditions. Visitors call on us each day, and we want our general appearance to be the best at all times. By doing your part, you are making the company a better place to work.

Use of Telephone

Please be courteous and observe these few rules of telephone etiquette:

- Answer the telephone promptly and identify yourself.
- Be sure that your telephone is attended when you are away.
- If you have a button set, learn how to use it. You can cut off important calls by indiscriminate button-pushing.
- If you use the hold-button, check back with the call being held to assure the caller that you are still on the line.
- If your secretary places your calls, be sure to pick up the line before she obtains your party.
- **Please don't tie up our business lines with endless personal conversations.**

Company procedures

Confidential Information

In the course of business, you may obtain information which is confidential. Confidential business matters should not be discussed in elevators, restaurants or other public places. Limit the distribution of confidential information to those who **must** know. As a rule, all such material should be locked in files or cabinets. When you have visitors, be sure confidential memoranda are not visible.

Solicitations and Gifts

To avoid embarrassing your co-workers, please refrain from solicitations of any kind on Company premises. The practice of soliciting for charities, pools or individual gifts may place employees in an awkward position if they feel compelled to contribute even though they have no desire to support a particular activity. If you have any questions about this, please see your supervisor.

Safety

We ask your cooperation to assure that our company is a safe place to work. Report to your supervisor any unsafe condition or hazards you may observe. If an accident should occur, report it to your supervisor immediately, no matter how minor it may appear. Supervisors should report all accidents to Personnel immediately. We are making every reasonable effort to comply with the Federal Occupational Safety and Health Act.

Changes in Personal Status

Records of employees are kept in the Personnel Department. Keeping your individual data current will prevent delays in receiving paychecks and various benefits. Also, in case of sudden illness, we would like to know where you are and whom to notify. It is important to you that you notify the Personnel Department in the event of the following changes:

- Your name (legally)
- Your home address and telephone
- Marital status
- Your beneficiary (life insurance, pension plan, etc.)

Lost and Found

If you have lost any of your personal belongings and a thorough search does not turn it up, contact the Personnel Department. Chances are, someone has turned it in for safe-keeping.

Submit "found articles" to the Personnel Department. Personnel will make every reasonable effort to locate the owner.

Employee Referrals

In a continuing effort to seek the best qualified employees, the Company offers a $25.00 finder's fee for referring qualified applicants to us. Payment of this fee is subject to satisfactory completion of the new employee's probation period. You are excluded from this policy if you are in a personnel or recruiting function.

Service awards

Your years of service are given special recognition in the following ways:

After five years with the Company, you will receive the silver service pin and will be treated to a luncheon by your supervisor.

After ten years with the Company, you will receive the gold service award and will be treated to a special luncheon. At this time, you will also be presented with a $100 anniversary bonus.

After twenty-five years with the Company, you will receive a special anniversary bonus equivalent to one full month's salary. At this time, you will also be guest of honor at a cocktail party and dinner where you will be presented with a gold watch.

Other company benefits

Credit Union

The NAP Federal Credit Union offers you the opportunity to save money at a high dividend rate and borrow at competitive interest rates -- all through your own financial institution. Through the Credit Union you can also:

- have payroll deductions made for savings, Christmas clubs, vacation clubs, sharedraft (checking) accounts or repaying loans.
- use the Net Pay Direct Deposit Program for deposits to sharedraft (checking) or savings accounts.
- purchase various certificates of deposit.
- open an insured Individual Retirement Account.
- open accounts for family members.

For your convenience the Credit Union office is open Monday thru Friday, 9 a.m. to 4 p.m.

Recreation Club

You and your immediate family are eligible for membership in the NAPC Recreation Club, Inc. The Club promotes good fellowship and friendly relations among employees, both active and retired. To this end, the Club sponsors social and recreational activities for your entertainment, your benefit and your welfare. These include special events such as travel programs, educational activities and sporting events. Contact the Personnel Department for further information and applications.

Sports & Games

In past seasons, the NAPC Recreation Club has scheduled intra-Company and city-league competition, including baseball and bowling teams and golf tournaments.

If a sufficient number of employees show interest in participating in a particular activity, there is a possibility of organizing events in backgammon, bridge, chess and English darts as well as baseball, bowling, tennis and golf tournaments.

Interested employees should contact George Elliot of the NAPC Recreation Club (EXT. 264).

Other company benefits (continued)

Educational Assistance

The Company offers you an opportunity to prepare yourself for more responsibility and higher pay. To encourage you to become more efficient on the job, and to increase your potential development for the Company, we have established a tuition refund plan.

Under the plan, expenses for courses relating to your area of responsibility, as well as degree-oriented courses, will be refunded at the rate of 100%. A maximum of six credit hours per semester will be considered for tuition aid.

To be eligible, you must be a full-time employee before beginning and after completing the course. You must also complete a tuition reimbursement form and have it approved by your manager before the course starts. You can obtain the reimbursement form from the Personnel Department.

Scholarship Program

Under this program, North American Philips awards four-year college scholarships to employees' children. Awards are made to college bound high school seniors on the basis of their academic and personal achievements as well as financial need. Application forms and a booklet describing the program in detail are available in the Personnel Department.

Matching Gift Program

When you contribute money to a U.S. college, university or independent secondary school, NAPC will match your contribution. Matching gifts can range from a minimum of $10 to a maximum of $500 a year for any one employee. To find out how to have your gift matched, take a brochure from the Matching Gift display on your bulletin board. If no brochures are left, see the Personnel Department.

Vacations

To provide you with a period of relaxation and change from the normal work routine, liberal vacation benefits have been established.

General

The normal vacation period runs from January 1 through December 31. If a recognized holiday occurs during your scheduled vacation, an additional day off will be granted. You will not be eligible for pay in lieu of vacation.

You should schedule your vacation according to departmental requirements and must have your department head's approval. You may not carry vacation over from one year to the next. The number of days in a full vacation (two weeks or more) need not be scheduled consecutively but you may not take a vacation in units of less than one week unless you get the approval of both the department head and Personnel Department.

New Employees (employed less than one year)

If You Are Employed On or Before ...	Your Vacation Days Are ...
Sept. 1	10 in next calendar year
Oct. 1	9 in next calendar year
Nov. 1	8 in next calendar year
Dec. 1	7 in next calendar year
Dec. 31	6 in next calendar year
Jan. 2	6 in current calendar year
Feb. 1	5 in current calendar year
March 1	4 in current calendar year
April 1	3 in current calendar year
May 1	2 in current calendar year
June 1	1 in current calendar year

New employees will be eligible to take earned vacation only after completing six months of service.

Employees With More Than One Year Of Service

Length of Service	Vacation Allowance
1st through 5th year	2 weeks (10 working days)
On January 1st following completion of 5th year	3 weeks (15 working days)
On January 1st following completion of 15th year	4 weeks (20 working days)

Vacations (continued)

Terminations

Less than six months service – If you are terminated or resign, you will not be eligible for vacation pay.

Six months but less than one year's service – If you are terminated or resign and give two weeks notice, you will be eligible for vacation pay on the basis of one day for each month of service to a maximum of ten days, less any vacation time taken.

One year's service or more – If you resign and give two weeks advance notice, or are terminated, you will receive your current year's vacation pay less any vacation time already taken in the current year.

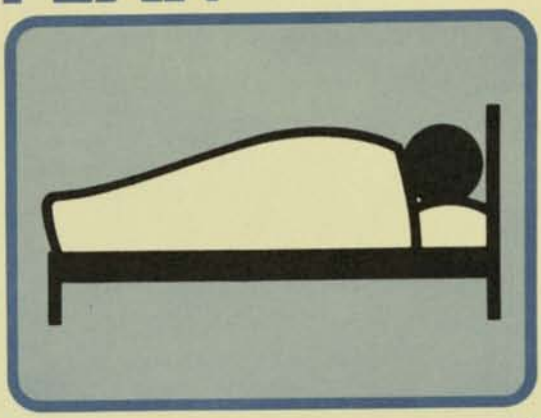
Holidays

At the beginning of each year a schedule will be distributed reflecting the actual days observed by the Company. The schedule may vary from year to year but a typical recent schedule included:

New Year's Day	Labor Day
Washington's Birthday	Thanksgiving Day
Memorial Day	Day after Thanksgiving
Independence Day	Christmas Day

In addition to the holidays listed above, a "floating" holiday may also be granted with supervisory approval. Floating holidays will not be permitted during the 90 day probation period.

HEALTH PLAN



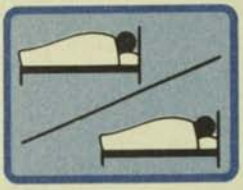
Your health plan

Your health plan (continued)

Why a health plan?

Probably nothing in life holds more importance for you and your family than good health. A serious illness can make all other problems seem insignificant.

This section describes our two health plans. You can choose the one that best suits your needs. But no matter which plan you choose, it's sure to protect you and your family from the heavy financial burden that sickness or accidents can impose.



Your choice between two plans

Different people have different needs for health insurance. And a person's insurance needs can change (for example, after marriage or having children). To accommodate varying needs, you can choose between two Company-provided health plans.*

Both plans cover the same broad range of medical services and supplies — from hospital room and board, surgery and doctors' bills (other than for routine check-ups) to lab tests, X-rays and prescription drugs. What makes the plans different is the *amount* each will pay and the cost of coverage. Very briefly. . .

The **Comprehensive Plan,** in general, requires that you pay a deductible before any plan payments can start. After the deductible is met, the plan pays 85% of reasonable and customary covered charges and you pay the remaining 15%. The Company pays the full cost of the Comprehensive Plan. You pay nothing to cover yourself and all your eligible dependents.

The **Basic/Major Plan,** as its name suggests, is made up of two parts. In general, the Basic portion of the plan covers hospital room and board, surgery and certain other expenses at 100% of reasonable and customary covered charges *without* requiring a deductible.

When expenses are not covered under Basic Medical, or when they exceed Basic's limits, the Major Medical portion usually steps in. After the deductible is met, Major Medical pays 80% of reasonable and customary covered

*Health insurance through a Health Maintenance Organization (HMO) may be available as an alternative to the Company-provided plans. Please see page 57 for an overview of HMOs.

charges, while you pay the remaining 20%. The Company pays most of the cost of providing this plan. You share the cost by contributing $20 for individual coverage or $40 a month for family coverage.

Some Special Features

Both plans include special features that are designed to

- **encourage** wise use of medical resources (for example: whenever possible, use a same-day surgical facility in favor of surgery while a hospital inpatient)
- **help** you become an informed consumer when it comes to your own health (for example: get a second opinion for certain surgical procedures)
- **prevent** hospitals from filling their beds when not medically necessary (for example: use the Pre Admission Review program (PAR) to get authorization for your hospitalization; opt for medical care at home — in a comfortable, supportive atmosphere)
- **enlist** your help in controlling runaway health care costs that have become a major national concern.

What's your incentive to help meet these goals? First and foremost, your incentive is to gain *quality medical care* that's most appropriate for your needs. There is also a dollar incentive: In a selected number of situations, you receive *more money* from the plan if you follow certain procedures — and *less money* if you don't.

For example, say you are considering a tonsillectomy for your child. Because it's an undisputed fact that many tonsillectomies are performed when not medically necessary, both our health plans require a second surgical opinion for this procedure. Your *first* incentive to follow through with a second opinion is to be certain that surgery is the most sound medical solution for your child's problem. As for the dollar incentive — if you *do* get a second opinion and decide on surgery, your plan will pay the surgical bill in the usual way. If you *don't* get a second opinion, the plan will pay substantially *less*. In other words, by being an informed consumer you gain the reassurance that your child's operation is really necessary and you *save money too!*

$ $ SAVE $ $

We want to make sure you always get the most appropriate, quality medical care *and* the highest benefit available under the plan you choose. So those situations where you can make decisions in your best interest, and save money besides, are highlighted in **$ $ SAVE $ $** boxes like this one. Please read those areas with care.

How this section is organized

On the next page, you'll find a pull-out chart that compares the Comprehensive Plan to the Basic/Major Plan. The chart is designed to give an overview of main features at a glance. But remember: To fully understand the plans and to get maximum benefit from them, *there's no substitute for reading the full plan description.*

Following the chart is a complete description of each health plan. Each page is marked to show whether it applies to the Comprehensive Plan, the Basic/Major Plan, or both.

HOW THE PLANS COMPARE: AT A GLANCE

Feature	Comprehensive Plan	Basic/Major Plan
Covered Charges	Hospital room, board and miscellaneous charges; surgery; diagnostic tests; and a broad range of outpatient medical services and supplies.	**Basic Portion:** Hospital room, board and miscellaneous charges; surgery; diagnostic tests (up to $100) **Major Medical Portion:** Broad range of outpatient medical services and supplies not covered under Basic.
Your Cost	You pay nothing.	• $20 per month/individual coverage • $40 per month/family coverage
The Deductible	• $200 if individual coverage • $400 if family coverage } applies to most covered charges	• $150 if individual coverage • $300 if family coverage } applies only to Major Medical covered charges
What the Plan Pays (Assuming any hospitalization is authorized through Pre Admission Review)	After deductible, Plan pays 85% of most covered charges. (You pay remaining 15% "co-insurance.")	Plan pays 100% of Basic covered charges, with no deductible. After deductible, Plan pays 80% of most Major Medical covered charges. (You pay remaining 20% "co-insurance.")
Full Payment Protection	Plan pays 100% of a calendar year's covered charges after your deductible plus 15% co-insurance reaches • $1,500 if individual coverage • $3,000 if family coverage	Plan pays 100% of a calendar year's covered charges after your deductible plus 20% co-insurance reaches • $1,500 if individual coverage • $3,000 if family coverage
Special Features	Subject to Plan rules, pre-admission hospital tests, home health/extended care, second surgical opinion consultation, emergency care, outpatient surgery and generic prescription drugs MAY BE COVERED AT 100%, WITH NO DEDUCTIBLE.	
EXAMPLE 1–Outpatient (Assuming individual coverage) You experience stomach problems. As a result, in one calendar year, you • See a doctor 5 times: $300 • Take diagnostic tests: $130 • Require prescription drugs: $110 **Total Covered Charges:** $540	Covered Charges Are: $540 You Pay Deductible: −200 $340 × 85% Plan Pays 85%: $289 You Pay 15% Co-insurance: $ 51 **IN TOTAL** • Plan Pays $289 • You Pay **$251*** *Deductible and co-insurance—no charge for coverage	Basic Portion Pays up to $100 for Diagnostic Tests at 100%, With No Deductible $100 Remaining Covered Charges Are: $440 You Pay Deductible: −150 $290 × 80% Major Medical Pays 80%: $232 You Pay 20% Co-insurance: $ 58 **IN TOTAL** • Plan Pays $332 • You Pay **$448*** *Deductible, co-insurance and $240 annual contribution for coverage
EXAMPLE 2–Inpatient (Assuming individual coverage) You are hospitalized for an operation. Your covered charges are • Hospital room, board and miscellaneous expenses: $4,200 • Surgeon's fee: 1,100 • Private duty nursing: 620 • Prescription drugs after release: 100 • Doctor's fees after release: 300 **Total Covered Charges:** $6,320	Covered Charges Are: $6,320 You Pay Deductible: − 200 $6,120 × 85% Plan Pays 85%: $5,202 You Pay 15% Co-insurance: $ 918 **IN TOTAL** • Plan Pays $5,202 • You Pay **$1,118*** *Deductible and co-insurance—no charge for coverage	Basic Portion Pays Hospital Charges and Surgeon's Fee: $5,300 Remaining Covered Charges Are: $1,020 You Pay Deductible: − 150 $ 870 × 80% Major Medical Pays 80%: $ 696 You Pay 20% Co-insurance $ 174 **IN TOTAL** • Plan Pays $5,996 • You Pay **$ 564*** *Deductible, co-insurance and $240 annual contribution for coverage

Who is eligible?

If you are an active, full-time, salaried employee, you are eligible for health insurance after you have been with the Company for one month. ("Full-time" means that you are regularly scheduled to work at least 30 hours per week.) Your husband or wife (unless legally separated or divorced) and unmarried children from birth up to their 19th birthday can be covered as your "dependents" under whichever health plan you elect for yourself.

- **Children** — Children eligible for coverage include . . .

  — your own children,

  — stepchildren,

  — adopted children, or

  — any children permanently residing in your household in a parent-child relationship

  . . . provided that they are primarily dependent upon you for support.

- **Students** — Coverage will be continued for your unmarried children up to their 25th birthday while they are attending school as full-time students and are primarily dependent upon you for support.

- **Handicapped Child** — If you have a mentally retarded or physically handicapped child, his or her benefits may continue for as long as he or she remains handicapped and dependent upon you. To have benefits continued, you must provide satisfactory evidence of the handicap to the insurance company. Contact your Personnel or Employee Relations Office at least 31 days before your handicapped child's normal benefit termination date.

If your husband or wife is also an employee of the Company, you may both enroll for individual coverage or you may include each other as a dependent under family coverage. Both of you may cover your children. However, the coordination of benefits provision explained on page 58 will apply.

How to enroll

Comprehensive Plan

Coverage for you and your eligible dependents will take effect on the date you complete a month of employment — provided you enroll before that date. If you file your form after your first month, coverage takes effect on the date you enroll.

Basic/Major Plan

You can enroll yourself and all your eligible dependents by filing a form within your first month of employment. If you do, coverage takes effect after one month on the job.

If you do not file a form to join either Company-provided health plan within your first month, you can still join the Basic/Major Plan within the next 31 days. Coverage takes effect the date you file your form.

However, you cannot file for coverage under the Basic/Major Plan more than 60 days after hire. After those 60 days, you and your dependents will be covered automatically under the Comprehensive Plan.

New Dependents

If you are enrolled for individual coverage and then gain an eligible dependent (e.g., get married or have a child), you must notify the Company that you want to enroll for dependent coverage before your dependent can be covered.

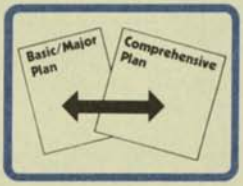
If you enroll your dependent *within* 31 days of the date a person became your dependent, coverage will be retroactive to that date. If you file *after* those 31 days, coverage for the dependent will start when you enroll. Plus, if you're enrolling in the Basic/Major Plan after 31 days, you must also provide satisfactory evidence of the dependent's good health to the insurance company before the dependent can be covered. The dependent's insurance will take effect when the insurance company approves the coverage.

How to enroll (continued)

Delayed Enrollment

If you are absent from work because of injury or illness on the day your insurance would otherwise become effective, the effective date of coverage for you and your family will be postponed until the date you return to work.

If a member of your family is in the hospital on the date dependent's coverage is to take effect, coverage will be postponed until the date he or she is discharged from the hospital. This limitation does not apply to newborn children, who are covered from birth.



Switching from plan to plan

If you are enrolled in the Basic/Major Plan, you can change to the Comprehensive Plan on any January 1. All you need do is file an enrollment change form.

If you enroll in the Comprehensive Plan, you can switch to the Basic/Major Plan only after you

- have been in the Comprehensive Plan for a continuous one-year period, and
- submit proof of good health to the insurance company for yourself and any dependents you wish to enroll.

Basic/Major coverage takes effect on the January 1 after you meet both of these requirements. If the insurance company does not approve your application — because you or any dependent cannot prove good health — you and your dependents will remain covered under the Comprehensive Plan.

EXCEPTION: If your spouse becomes unemployed (thereby losing his or her group insurance coverage), you can immediately switch from the Comprehensive Plan to the Basic/Major Plan. There is no need to comply with the waiting period or provide proof of good health. However, you will have to provide proof that your spouse left his or her job.

THE COMPREHENSIVE PLAN

In broad terms, the Comprehensive Plan works like this:

- Each calendar year, you pay a "deductible."
- Then, the plan pays 85% of remaining covered charges for the rest of the calendar year (except outpatient psychiatric/drug abuse charges, as explained on page 25).

However, certain covered charges are paid at 100% with no deductible. These opportunities for higher than usual coverage are clearly marked in **$ $ SAVE $ $** boxes.

Reasonable And Customary/Medically Necessary

The *kinds* of services and supplies for which plan benefits are payable are called "covered charges." Covered charges are reimbursed to the extent they are "reasonable and customary."

To determine whether charges are reasonable and customary, the insurance company considers such things as the nature and complexity of the medical services, the usual range of fees charged by most doctors who perform these services in the same location, and whether any of the charges were for the unnecessary repetition of tests.

The plan will not cover any services or supplies which are not medically necessary. This means services or supplies that are not needed for diagnosis or treatment under generally accepted health care practice — even if ordered by a doctor. For example, repeated tests or treatments which are not needed or days in the hospital when not medically necessary will not be covered by the plan. The insurance company has the final say in determining if a service or supply is *reasonable and customary* and *medically necessary.*

Your cost

The Company pays the full cost of protecting you and all your eligible dependents. You pay nothing for Comprehensive Plan health coverage.

The deductible

Before you can receive Comprehensive Plan benefits, you must pay a certain dollar amount of covered charges. This is called a "deductible." The deductible must be met each calendar year. You can satisfy the deductible with expenses from more than one illness or injury.

Individual Coverage. If you have individual coverage, you must meet a $200 deductible each calendar year.

Family Coverage. If you have family coverage, the $200 deductible applies separately to each covered person. However, a special rule can limit your family's deductible expenses.

If, during a calendar year, two or more family members incur a total of $400 in covered charges (but not counting more than $200 on account of any one individual), you meet the "family deductible." This means all covered family members become eligible for medical benefits for the rest of the calendar year.

Here's an example of how this special rule helped to limit one family's deductible expenses in one calendar year.

Family Member	Covered Charges
Spouse	$150
Child	$120
Employee	$130
Total Deductibles:	$400

FAMILY DEDUCTIBLE MET

At this point, all covered family members are eligible for medical benefits. No further deductible expenses need be met for the rest of the calendar year.

In determining when the deductible is met, bills are considered in chronological order — based on the date the service is performed.

Family Accident

If, while insured, more than one member of your family is injured in the same accident, only a single $200 deductible applies. You must file a separate benefit claim for each person.

What the Comprehensive Plan pays

After you have satisfied the deductible for the calendar year, the Comprehensive Plan pays 85% of reasonable and customary covered charges. You pay the remaining 15%. Because you share a portion of the expense, this coverage is called *co-insurance.*

There is *no dollar limit* on how much the Comprehensive Plan will pay.

Special Full Payment Feature

Generally, the 15% share of covered charges comes to an amount most people can handle comfortably. However, in cases of serious or prolonged illness, that 15% share could seriously threaten income or savings.

So the plan has this valuable full payment provision, commonly called a "stop-loss." If in any calendar year, your out-of-pocket expenses reach $1,500 (or $3,000 if you have family coverage), the plan pays 100% of covered charges for the rest of the calendar year. Out-of-pocket expenses include the deductible and your expenses at the 15% rate.

IMPORTANT: Charges for outpatient psychiatric services, alcoholism and drug abuse treatment, as detailed on page 25, charges above the reasonable and customary amount, or charges not considered medically necessary, *will not be used* to satisfy the stop-loss, and won't be subject to the 100% reimbursement.

Also, any charges that are not covered because

- you did not use the Pre Admission Review program (PAR) to get authorization for hospitalization (see page 11), or
- you failed to get a required second surgical opinion (see page 20)

will not count toward meeting the stop-loss. Nor will any of those charges be reimbursed *even if you have already met the stop-loss.*

Covered charges

The following services and supplies described on pages 11 through 27 are covered under the Comprehensive Plan.

Hospital care

$ $ SAVE $ $

PRE ADMISSION REVIEW (PAR)

To ensure the quality of care and appropriateness of any hospital stay, the health plan includes a Pre Admission Review program — called PAR, for short. Under this program, all non-emergency hospitalizations must be approved *before admission.* In case of an emergency, approval can be obtained within 48 hours *after admission* (or within 72 hours on weekends or holidays). If you don't get proper approval, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%.**

For example, say you're admitted to a hospital and your covered hospital charges (after the deductible) come to $4,000.

- If you used PAR, the plan would pay $3,400 ($4,000 x 85%).
- If you did *not* use PAR, the plan would only pay $2,720 (regular $3,400 benefit x 20% = a $680 reduction in benefits).

As you can see, it is extremely important that you understand how PAR works and use it each and every time you or a dependent is hospitalized. So please be sure to read about required Pre Admission Review behind the red guidebook tab marked "PAR."

Whenever you are confined in a legally constituted and operated hospital, the plan pays 85% of the semi-private or ward charges for the first 365 days of each confinement. This includes miscellaneous charges for such things as X-rays, drugs, laboratory exams, operating room and anesthesia as well as room and board charges.

Private Room. If you stay in a private room, the plan pays 85% of the hospital's *most common* semi-private room charges during the first 365 days. However, there are a few important exceptions to this private room limitation:

Hospital care (continued)

- If your hospital has no semi-private rooms, 90% of the private room charge will be covered at the usual 85% rate.
- If a doctor determines that your condition requires a sterile environment to keep you from contracting an infection or spreading infection, the full private room rate will be covered at 85%.
- If a sterile environment is required due to impairment of the immunological system (for example, after chemotherapy), the full private room rate will be covered at 85%. There must be medical documentation to prove medical necessity for the isolation room.

Intensive Care. If you are confined in the hospital's intensive care unit (that is, one that provides care for critically ill patients other than normal post-operative recovery care), the hospital's intensive care room rate will be covered at 85%.

Hospital Defined. Hospital charges are only covered when you're confined in a legally constituted and operated institution which has, on its premises, organized facilities for the care and treatment of sick or injured people. These facilities must be supervised by a staff of legally qualified physicians and must have a registered professional nurse on duty at all times. Charges *will not* be considered covered hospital charges if treatment takes place in any institution — or any part of an institution — that

- is used principally as a rest or nursing facility
- is used principally for care of the aged, chronically ill, convalescents, drug addicts or alcoholics (except as described on page 19)
- primarily provides custodial, educational or rehabilitory care.

Pre-Admission Testing

Hospitals routinely require a number of tests before they will start any treatment. But it's usually not medically necessary to perform these pre-admission tests while you're an inpatient. So, whenever possible, arrange to do your pre-admission testing (PAT) as an outpatient or through an approved independent laboratory.

By using PAT, you can shorten your hospital stay by one or two days — allowing you to carry on with your normal routine at home or at work.

All reasonable and customary PAT charges will be paid at the special 100% rate with no deductible provided

- you are hospitalized within 7 days after the tests are performed, and
- the tests are normally required and accepted by the hospital in place of tests that would otherwise have been performed after admission.

$ $ SAVE $ $

Pre-admission testing can let you stay comfortably at home until hospital admission is medically necessary. The Comprehensive Plan will pay *100%* of reasonable and customary PAT charges, *with no deductible.*

Plus, if PAT keeps you out of the hospital for a day or so, you avoid the 15% co-insurance for hospital charges during those days.

Friday/Saturday Admissions

In many cases, hospital admissions on a Friday or Saturday are good for filling empty hospital beds — and not much else. That's because tests and other medical procedures generally are not performed on those days.

Therefore, the plan will not pay hospital charges for a Friday or Saturday admission *unless*

- you're admitted for childbirth or a medical emergency,
- you're admitted to an approved alcohol or drug rehabilitation facility as defined on page 19, or
- treatment is actually performed on the Friday or Saturday, as certified by the hospital and attending physician.

$ $ SAVE $ $

If you're admitted on a Friday or Saturday, you get *no* hospital benefits for those days (except in the three circumstances listed above). You will, however, receive the regular 85% benefit for the remainder of your confinement.

If you're admitted on any other day, you get *regular plan benefits.*

Outpatient emergency care

If you or one of your family members has an accident and receives *emergency medical treatment within 48 hours after the accident occurs,* the plan will pay 100% of the following charges for such treatment:

- outpatient medical services and supplies at a hospital;
- doctor's treatment in the hospital or *elsewhere;*
- X-ray or laboratory examinations at a hospital or *elsewhere;*
- professional ambulance charges up to $20.

If the accident is so serious that you must be confined to a hospital, the regular hospital benefits described on page 11 will be paid — provided you get authorization for your hospital stay through the Pre Admission Review program (PAR). If this is not done within the required time after admission, **THERE WILL BE A 20% CUTBACK IN HOSPITAL BENEFITS,** as explained on page 11.

You'll find details about PAR behind the special red guidebook tab.

Home health care/extended care

The previous pages describe the benefits available while you're in the hospital. However, there may come a time when you're well enough to leave the hospital, but not well enough to go without some continued care. In this case you may be entitled to home health care or extended care. These benefits are available if

- you were a hospital inpatient due to the same medical condition for at least three days during the 14 days right before extended care begins, and
- your need for home health care or extended care is medically necessary and certified by the licensed physician in charge of your case.

Home health care may be covered if used in place of hospitalization — even if you were not a hospital inpatient before home health care begins.

Home health care/extended care (continued)

Home Health Care Benefits

Home health care benefits are available when you are essentially confined to your home and require intermittent nursing, therapy or other services. Services must be provided by an approved Home Health Care Agency and performed by or under the direct supervision of a registered or licensed practical nurse in accordance with a plan or treatment established and periodically reviewed by your physician. A Home Health Care Agency is "approved" if it meets standards set by Medicare.

Covered charges include • services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) • medical and surgical supplies and rental or purchase of durable medical equipment • physical, occupational, speech and respiratory therapy • home health aid services • nutritional guidance • diagnostic services • oxygen and its administration • hemodialysis.

Be sure to check with your Personnel or Employee Relations Office to determine if the durable medical equipment you need will be covered and if it should be rented or purchased.

$ $ SAVE $ $

The Comprehensive Plan pays 100% of covered reasonable and customary home health care charges. Plus, there is no deductible. The maximum benefit per illness is $3,000.

In other words, if home health care keeps you out of the hospital, you save the 15% co-insurance charges associated with a hospital confinement.

Exclusions. Home health care benefits *do not* cover • custodial care or care of the aged • meals • physician's services • housekeeping services • drugs and biologicals • services performed by relatives or members of your household • care for tuberculosis, alcoholism or drug addiction • care for senility, mental deficiency or retardation • non-medical personal care services.

(Physicians' services, drugs and biologicals and care for tuberculosis, alcoholism or drug addiction may be covered at the usual 85% rate.)

Extended Care Facility Benefits

When you're released from the hospital, your Comprehensive Plan benefits can continue if you still require professional and practical nursing care, you enter an approved Extended Care Facility and remain under the active medical supervision of a licensed physician. An Extended Care Facility is "approved" if it meets standards set by Medicare.

$ $ SAVE $ $

Your Comprehensive Plan pays

- 100% of the Extended Care Facility's room and board charges for up to 31 days per confinement — to the extent the charge does not exceed one-half of your hospital's semi-private room rate, and
- 100% of reasonable and customary charges for other medically necessary ,covered services and supplies during your confinement.

If you were in a hospital instead of an Extended Care Facility, you would have to pay the usual 15% co-insurance charge. So, by leaving the hospital as soon as medically possible, you can save many co-insurance dollars. And there's no deductible.

If you leave an Extended Care Facility and are later re-admitted, you'll be entitled to another 31 days' benefits *only* if

- at least 90 days have passed since you last left an Extended Care Facility, or
- the medical condition that causes readmission is unrelated to the condition that caused your earlier confinement.

Exclusions. Extended care benefits are *not* payable for • confinement which is principally for custodial care or care of the aged • care for tuberculosis, alcoholism, or drug addiction • care for senility, mental deficiency or retardation.

Hospice care

Nothing causes more physical, emotional and financial stress than having to deal with terminal illness. For this reason, your health plan includes special benefits for "hospice services." Hospice services are designed to meet the exceptional needs of a terminally ill patient and his or her family.

When Benefits Are Payable

Hospice benefits are payable when

- the patient's attending physician certifies that you or a dependent covered under the plan is expected to live less than six months, and
- the patient enters an approved hospice program. A hospice program is "approved" if it meets standards set by the insurance company.

If you're considering a hospice program, be sure to contact your Personnel or Employee Relations Office. They will check with the insurance company to see if the program is approved.

What Is Covered

Care through a hospice program may be provided on an inpatient or outpatient basis. For example, care in a specialized hospice facility, hospital or at home may all be covered.

During The Patient's Lifetime. The following services are covered during the patient's lifetime — if considered medically necessary by the patient's attending physician, approved by the insurance company, and billed through a hospice program:

- Room and board expenses in:
  - —a hospice facility located within a hospital, up to the hospital's most common semi-private room and board rate
  - —an approved free-standing, inpatient hospice facility, up to the most common semi-private room and board rate for hospitals in the general area.
- Skilled nursing and home health aid, if performed by a registered graduate nurse or licensed practical nurse.
- Counseling for the patient and other family members who are enrolled in the health plan, if administered by a psychiatrist, psychologist or a member of a state-licensed social services organization. The patient's primary physician must determine that the terminal illness is the direct cause of the need for counseling.

Hospice care (continued)

- Homemaker services, if the patient's family is unable to attend to the patient's needs.
- Local ambulance or special transport between the patient's home and the hospice facility.
- Miscellaneous services, such as: medical supplies, drugs and medication, physicians' services and rental or purchase of durable equipment.

During Bereavement. During the six months following the patient's death, the plan covers up to 12 counseling sessions for family members who are enrolled in the health plan by a psychiatrist, psychologist or a member of a state-licensed social services organization.

What The Plan Pays

The Comprehensive Plan pays 85% of the reasonable and customary covered charges explained above — after the patient's deductible has been met.

The maximum benefit payable for all covered hospice charges is $10,000. Any benefits payable under other areas of the health plan are not included in this maximum.

What Is Not Covered

The plan does not pay benefits for the following services or treatments under the hospice care program:

- Volunteer services or other services that would normally be provided free of charge.
- Legal and/or financial advice services (such as, preparation and execution of a will, estate planning and liquidation, financial investment).
- Counseling by the clergy or any volunteer group.
- Services of a person who ordinarily resides in the home of the patient or a member of his or her family or spouse's family.
- Services not provided and billed through the hospice program and not approved by the patient's attending physician and the insurance company.

Alcoholism/drug abuse rehabilitation

If you are admitted as an inpatient to an inpatient institution for the treatment of alcoholism or drug abuse, the plan pays benefits just as it would for treatment in a hospital. These benefits are available to you and your dependents and will only be paid for 45 days per person in a calendar year. Treatment must take place while the patient's health insurance is in effect.

Inpatient treatment for alcoholism or drug abuse must be approved *before admission* through the Pre Admission Review program (PAR). **FAILURE TO GET PAR APPROVAL WILL RESULT IN A 20% REDUCTION IN BENEFITS** (as shown in the example on page 11). For details on how PAR works, please read the special guidebook section marked "PAR."

The benefits will only be paid for two periods of confinement in one person's lifetime. Successive periods of confinement will be considered as one confinement if they are separated by less than seven days.

For this benefit, an inpatient institution means a legally constituted, operated and approved rehabilitation unit licensed by the state or approved by the insurance company. Such facilities provide medical treatment for patients who require inpatient care and have specified medical conditions. They have permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time registered professional nurse (R.N.), and they maintain daily medical records on all patients. **Before admission, please check with the Personnel or Employee Relations Office to make sure the services of the facility you are considering will be covered.**

The Friday/Saturday admission exclusion (see page 13) does *not* apply to admission for treatment of alcoholism or drug abuse.

Surgery

The Comprehensive Plan also covers surgery performed by a legally qualified doctor. Benefits are payable no matter where the operation is performed — in

- a hospital*
- doctor's office
- outpatient department of a hospital
- an approved ambulatory surgical facility (sometimes called a "Surgicenter")

The plan usually pays up to 85% of reasonable and customary charges for each operation. But you can receive more, as explained later under "Same-Day Surgery."

If you have more than one operation performed through the same incision, or in the same operative area, the plan covers only 85% of the reasonable and customary charge for the most expensive procedure. If, during one operation, two or more surgical procedures are performed in different operative areas with separate incisions, you will receive 85% of the reasonable and customary charge for the most expensive procedure and 50% of the charge for the other procedures.

Second Opinion Program

An important plan feature helps make sure you have surgery *only if you really need it.* It's called the "second opinion" feature. If you understand how it works and use it properly, you will

- **know the risks and alternatives:** Any surgery involves a degree of risk. A second opinion ensures complete, impartial information on what the risks are and what alternative treatment might be available.
- **make the best decision:** If your doctor's recommendation for surgery is backed up by a specialist, you can be confident that you're doing the best thing for your good health.
- **save money:** If you decide on surgery, the plan pays *more* if you get a required second opinion; it pays considerably *less* if you don't.

Best of all, a required second surgical opinion doesn't cost you a cent. The Company pays the full cost. Here are the details . . .

*REMINDER: If you intend to be hospitalized for your surgery, be sure to get authorization for your admission through the Pre Admission Review program (PAR).

Surgery (continued)

When You Need a Second Opinion. Careful medical studies show that certain surgical procedures often do not need to be performed. In other words, in many cases, the surgical risks outweigh the benefits — or an alternative treatment would be just as effective. These procedures are:

- **Bunionectomy** — removal of bunions
- **Cataract extraction** — removal of lens from eye
- **Cholecystectomy** — removal of gallbladder
- **Coronary Bypass** — open heart surgery
- **Hemorrhoidectomy (Internal)** — removal of internal hemorrhoids
- **Hysterectomy*** — removal of uterus
- **Inguinal Herniorrhaphy** — repair of inguinal hernia
- **Laminectomy/Chemonucleolysis** — removal of intervertebral disc/injection of enzyme into disc space
- **Laparotomy** — exploratory abdominal surgery
- **Ligation and/or Stripping of Varicose Veins** — varicose vein surgery
- **Mastectomy**** — removal of all or part of the breast
- **Meniscectomy** — removal of torn cartilage from knee
- **Oophorectomy** — removal of ovary or ovaries
- **Osteotomy** — large and small bone surgery of foot
- **Prostatectomy** — removal of all or part of the prostate
- **Salpingectomy** — removal of fallopian tube(s)
- **Submucous Resection (Nasal)** — repair of deviated septum of nose (covered only if performed for non-cosmetic reasons)
- **Strabotomy (Tenotomy)** — correction of crossed eyes ("strabismus")
- **Tonsillectomy/Adenoidectomy** — removal of tonsils or adenoids
- **Total knee or hip joint replacement** — replacement of joint with artificial prosthesis

*You do not need a second opinion before dilation and curettage (a "D&C").

**You do not need a second opinion before a breast biopsy.

Surgery (continued)

If your doctor recommends one of the above surgical procedures, **you must get a second surgical opinion through the insurance company's Managed Second Surgical Opinion (MSSO) Review Unit** to get maximum payment from the health plan. The insurance company is The Equitable.

Of course, *in an emergency,* you don't need to get a second opinion — whether or not the surgical procedure is on the list.

REMEMBER: Any doctor, even the best, can recommend surgery that's not really necessary — especially when dealing with a procedure that's not his or her specialty. So be sure to take advantage of the second surgical opinion. It's your guarantee that the surgery you elect is medically in your best interest.

$ $ SAVE $ $

If you get a second opinion for the procedures listed on the previous page, the plan will pay benefits the usual way — that is, 85% of the reasonable and customary charges for your surgery. If you don't get a second opinion, **the plan pays only 50% of your surgical bill, to the extent it is reasonable and customary.** (The reduction in benefits affects the bill for surgery only — not other related expenses such as hospital room and board.)

You are under no obligation to follow the advice of your second opinion consultant. As long as you go for the required second opinion through The Equitable's second opinion program, you will be entitled to normal plan benefits.

As mentioned earlier, you pay nothing for any required second opinion charges. The Company pays the entire cost. What's more, if the second doctor doesn't agree with your first doctor's recommendation, the plan will even pay for a third opinion through The Equitable's program.

How To Get A Required Second Opinion. Two simple steps are all it takes to get a required second opinion.

- First, call The Equitable's Managed Second Surgical Opinion (MSSO) Unit. **Their toll free number is 1-800-662-2273. (In Pennsylvania, dial 1-800-342-2399.)** Usually, your MSSO reviewer will ask you to choose a doctor from a list of specialists in your area. The reviewer will then schedule an appointment for you. In some cases, the reviewer can determine over the phone that surgery is clearly necessary. If so, you will

IMPORTANT: Please substitute this page 22/health REVISED for page 22/health in the HEALTH section. Note corrected Managed Second Surgical Opinion phone number.

not be required to go for a second opinion — and the plan will still pay the normal benefit.

- If your reviewer says you must go for a second opinion, tell your original doctor that your health plan requires a second opinion for surgery. Then ask him or her to forward your records and test results (lab, X-ray, etc.) to the second opinion consultant. This is becoming a common request, and your doctor will be happy to cooperate.

Be sure to give your Equitable reviewer your Social Security number plus your policy and branch numbers, as shown on your Health Insurance I.D. card.

If you must cancel or change an appointment that The Equitable has arranged for you, it is important for you to advise The Equitable of the change or cancellation.

You should not bring a claim form to the second opinion consultant. You do not have to pay for this consultation.

A second opinion is valid for six months. In other words, if you get a second opinion and let more than six months go by before your operation, you will have to get *another* second opinion to qualify for normal plan benefits.

What About Other Surgery? If you're considering surgery that's not on the previous list, we highly recommend that you still get a second opinion — because it may help you avoid unnecessary risks and costs.

To do so, you must arrange to see a specialist of your choice (you cannot use The Equitable's program for a referral). Reasonable and customary charges for the second opinion consultation will be covered at the usual 85% rate, after the deductible.

If you don't get a second opinion for surgery that's not on the list, the plan will still pay 85% of reasonable and customary surgical charges (*not* 50%).

Same-Day Surgery

No one likes to be hospitalized for surgery. Most people, and especially children, deal with surgery best when they can get back home to a comfortable, supportive atmosphere as soon as possible.

Therefore, it's fortunate that a great number of all surgical procedures — from simple tonsillectomies to delicate cataract surgery — can be performed in one day *without* hospitalization.

Surgery (continued)

You're encouraged to seek same-day surgery whenever possible, either in a doctor's office, outpatient department of a hospital or an independent facility that specializes in outpatient surgery.

$ $ SAVE $ $

If you elect outpatient surgery (in a doctor's office or other same-day surgical facility), the Comprehensive Plan pays 100% of reasonable and customary surgery charges, with no deductible. Related services and supplies provided by the facility or a physician on the day of surgery (such as anesthesia or biologicals) are also covered at 100%.

If you elected hospitalization instead, the plan would pay at the usual 85% rate. You would have to pay the deductible and 15% co-insurance.

Successive disabilities

Under the hospital and surgical coverage, you can receive the maximum benefits for each separate disability.

However, a hospital confinement or surgical operation is considered a continuation of a prior disability if:

- the cause of the later confinement or operation is related to the previous confinement or operation, or
- you did not return to active work between operations or periods of confinement, or
- for a family member, the later confinement or operation occurs within two months of the previous one.

If successive confinements or operations are considered continuous, all related bills are treated as part of one claim.

Generic prescription drugs

Usually, physicians prescribe drugs that carry the manufacturer's "brand name." A brand name drug can be *many times* as expensive as its non-brand name equivalent (called a "generic drug"). Yet there is no difference in quality. The chemical composition of a generic drug is the same as that of its brand name counterpart, and government-required quality control is equally strict.

Generic prescription drugs (continued)

Therefore, you should ask your doctor to prescribe generic drugs whenever possible. If you do, it will save you money.

$ $ SAVE $ $

If you use a generic drug, your claim will be covered in full. That means there is *no deductible,* and reimbursement is at *100% of the reasonable and customary charge.*

Non-generic prescription drugs are covered at the usual 85% rate after a deductible.

To get 100% payment for a generic drug, your pharmacist must write the word "GENERIC" on the bill and sign it.

Non-prescription ("over-the-counter") drugs are not covered under your health plan.

Doctor's charges: psychiatric services, alcoholism and drug abuse treatment

- **Inpatient Care:** For alcoholism, drug addiction, or mental and nervous disorders that are treated in the hospital, while confined, the Comprehensive Plan pays at the regular 85% level for covered expenses.
- **Outpatient Care:** You will be reimbursed 50% of reasonable and customary charges — up to a maximum covered benefit of $1,500 per year for
  - — professional psychiatric visits in a doctor's office or elsewhere when *not* confined to a hospital, if provided by a **legally qualified physician (M.D.) or licensed clinical psychologist (Ph.D.)**
  - — alcoholism and drug abuse treatment when *not* confined to a hospital or approved rehabilitation facility, if provided by a **legally qualified physician (M.D.) or licensed clinical psychologist (Ph.D.)**

Counseling by a marriage/family counselor, psychiatric social worker or other mental health professional (except as stated above) will **not** be covered.

Other covered charges

In addition to the services and supplies already described, the Comprehensive Plan covers *reasonable and customary charges* for all of the services and supplies listed below that are medically necessary and prescribed by a legally qualified doctor.

- Doctors' charges in connection with hospital confinements and office visits which are not related to hospital confinements (other than routine physicals).
- Outpatient medical services and supplies at a hospital and doctor's treatment in the hospital or elsewhere — when needed in connection with an accident or illness.
- Assistant surgeon's charges of up to 20% of the reasonable and customary charges for the surgical procedure.
- Anesthesiologist's charges — up to the reasonable and customary charge.

- The services of a registered nurse (R.N.) — or licensed practical nurse, if an R.N. is not available — except one who is a member of your family or who ordinarily lives in your home.
- Medications which require a physician's written prescription and which must be dispensed by a licensed pharmacist or physician. (Remember: Generic drugs can be reimbursed at 100% with no deductible. See page 24 for details.)
- Diagnostic X-ray and laboratory services.
- X-ray, radium and radioactive isotope therapy.
- Anesthesia and oxygen.
- Rental or purchase of a wheelchair, hospital-type bed, iron lung and certain other durable medical equipment. **Be sure to have the Personnel or Employee Relations Office check beforehand if the equipment you need will be covered and if it should be rented or purchased.**
- Initial cost of braces, artificial limbs or eyes. (Replacement costs will be paid only if the replacement is medically required.)
- Local professional ambulance service, when medically necessary.

Other covered charges (continued)

- Public transportation, as follows:
  - — to a local hospital for specialized treatment and back to your home
  - — to a specialized hospital or clinic and back to your home when a local hospital cannot provide the necessary care recommended by a physician
  - — from the place where disability occurs to the nearest hospital qualified to provide treatment
- Dental work or cosmetic surgery required as a result of accidental bodily injury which occurs while you are covered under the plan.
- Speech therapy by a qualified speech therapist for speech loss or impairment which results from an injury or sickness — not from a functional nervous disorder or congenital defect.
- Cardiac rehabilitation provided in an approved cardiac rehabilitation program when the program is rendered by a qualified hospital or extended care facility under the direction of a physician. **Be sure to check with your Personnel or Employee Relations Office to make sure that the program you are considering will be covered.**
- The following oral surgery procedures will be covered by the health plan:
  - — removal of cysts of the jaw
  - — stomatoplasty
  - — osteotomy

  Certain other oral surgical procedures may be covered under the health plan. **If you have any questions about coverage of oral surgery under this plan, contact your Personnel or Employee Relations Office.**
- Physical therapy services falling within the guidelines established by the insurance company.
- Chiropractic services, up to:
  - — 25 visits in the first 90 days
  - — 12 visits in the next 60 days
  - — 10 visits thereafter.

What's not covered

The Comprehensive Plan does not cover expenses for any of the following:

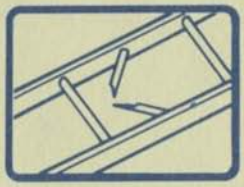
- Sickness or injury that is not treated by a legally qualified and licensed physician or surgeon
- Routine physical examinations
- Private nursing care by a member of your family
- If you occupy a private hospital room, charges in excess of the hospital's most common semi-private room charge (except as described on pages 11 and 12)
- Care or treatment in a government-owned or operated hospital
- Expenses that you are not legally required to pay

- Sickness or injury resulting from war or an act of war, or incurred while in the armed forces
- Any days of hospital confinement or any medical services which are not medically necessary
- Experimental medical treatment, therapy or surgery
- Drugs and medicines not approved by the FDA (Federal Drug Administration)
- Any charges resulting from injury or sickness connected with employment with any employer
- Eye refractions, optic training, eyeglasses, contact lenses, hearing aids or examinations for their prescription or fitting
- Care or treatment in other than a legally constituted and operated hospital as defined on page 12
- Care or treatment in any institution or part of an institution which is primarily a rest facility, nursing facility or facility for the aged, chronically ill, convalescents, drug addicts or alcoholics; also, one primarily engaged in custodial, educational or rehabilitory care — except as defined on page 19
- Drainage of an intraoral alveolar abscess, acute with cellulitis
- Dental work, treatment or appliances other than required as a result of accidental bodily injury or other than certain oral surgical procedures
- Exercise bicycles, whirlpools, treadmill joggers, environmental control equipment or other non-medical equipment

What's not covered (continued)

- Cardiac rehabilitation that is *not* provided in an approved cardiac rehabilitation program and rendered by a qualified hospital or extended care facility under the direction of a physician

IMPORTANT: See "Other Important Facts" on page 58 for other conditions that may affect coverage.



An example

You are injured in an accident, and are confined in a hospital for 10 days requiring surgery and private duty nursing as well as extensive treatment after you are discharged. You obtained authorization for your hospitalization through the Pre Admission Review program (PAR) within the required time after emergency admission. Here's how the Comprehensive Plan pays benefits:

	Total Charges
Hospital Semi-Private Charges — 10 Days at $150 per Day	$1,500
Miscellaneous Hospital Charges	$1,800
Surgeon's Fee	$ 750
Anesthetist's Fee	$ 150
Private Duty Nursing	$ 750
Drugs and Medicines After Discharge From Hospital	$ 120
Doctor's Fees After Discharge From Hospital	$ 230
TOTAL	$5,300
First you pay the $200 deductible:	- 200
	$5,100
Then the plan pays 85% of reasonable and customary covered charges:	x 85%
	$4,335
You pay the 15% co-insurance:	$ 765

Remember: The plan *limits* how much you ever have to pay in out-of-pocket expenses in any calendar year. ("Out-of-pocket expenses" means the deductible plus your 15% co-insurance amount.)

An example (continued)

Once out-of-pocket expenses in a calendar year reach $1,500 ($3,000 in case of family coverage), the plan pays 100% of reasonable and customary charges for the rest of the calendar year.

Please be sure to read pages 58 through 74. There, you'll find more important facts about the Comprehensive Plan.

THE BASIC/MAJOR PLAN

In broad terms, the Basic/Major Plan works like this:

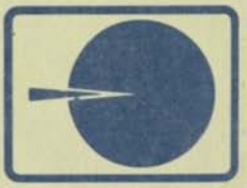
- The Basic portion of the plan covers hospital room and board, home health care, extended care, surgery, diagnostic testing and outpatient emergency care.
- The Major Medical portion covers many services and supplies that are not covered by Basic or that go above Basic's limits.

Reasonable And Customary/Medically Necessary

The *kinds* of services and supplies for which plan benefits are payable are called "covered charges." Covered charges are reimbursed to the extent they are "reasonable and customary."

To determine whether charges are reasonable and customary, the insurance company considers such things as the nature and complexity of the medical services, the usual range of fees charged by most doctors who perform these services in the same location, and whether any of the charges were for the unnecessary repetition of tests.

The plan will not cover any services or supplies which are not medically necessary. This means services or supplies that are not needed for diagnosis or treatment under generally accepted health care practice — even if ordered by a doctor. For example, repeated tests or treatments which are not needed or days in the hospital when not medically necessary will not be covered by the plan. The insurance company has the final say in determining if a service or supply is *reasonable and customary* and *medically necessary.*



Your cost

Individual coverage — for yourself only — costs you $20 a month. Family coverage — for yourself and all eligible dependents — costs $40 a month. Your contributions are made through convenient payroll deductions.

Before-Tax Contributions

By signing up for the Basic/Major Plan, you agree to make contributions through a reduction in your salary *before taxes are taken out.* As a result, the actual bite out of your take-home pay will be *less* than $20 a month (or $40 a month for family coverage).

Here's a quick way to estimate how much you might save by making contributions in before-tax dollars. Figure what you pay in taxes — as a percentage of your salary — and multiply that percentage by your contributions. For example, say your taxes come to 30% of your salary and you contribute $40 a month for family coverage. You could save about $12 a month by making before-tax contributions (30% x $40 = $12 savings). So even though you contribute $40 a month, your take-home pay is only reduced by about $28 ($40 less $12 saved).

Here are some other important points about before-tax contributions:

- "Taxes" mean federal income tax, most states' income tax and Social Security (FICA) tax. Because your before-tax contributions reduce your earnings for Social Security purposes, making such contributions may slightly decrease your Social Security benefit.
- Before-tax contributions for health insurance are allowed under current tax law. Should the tax law change, you will have to contribute in after-tax dollars, without the special savings just described.

YOUR BASIC BENEFITS

Hospital care

$ $ SAVE $ $

PAR

PRE ADMISSION REVIEW (PAR)

To ensure the quality of care and appropriateness of any hospital stay, the health plan includes a Pre Admission Review program — called PAR, for short. Under this program, all non-emergency hospitalizations must be approved *before admission.* In case of an emergency, approval can be obtained within 48 hours *after admission* (or within 72 hours on weekends or holidays). If you don't get proper approval, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%.**

For example, say you're admitted to a hospital and your covered hospital charges come to $4,000.

- If you used PAR, the plan would pay $4,000 ($4,000 x 100%).
- If you did *not* use PAR, the plan would only pay $3,200 (regular $4,000 benefit x 20% = an $800 reduction in benefits).

As you can see, it is extremely important that you understand how PAR works and use it each and every time you or a dependent is hospitalized. So please be sure to read about required Pre Admission Review behind the red guidebook tab marked "PAR."

Whenever you are confined in a legally constituted and operated hospital, the plan pays full semi-private or ward charges for the first 365 days of each confinement. This includes miscellaneous charges for such things as X-rays, drugs, laboratory exams, operating room and anesthesia as well as room and board charges.

Private Room. If you stay in a private room, the plan pays the hospital's *most common* semi-private room charges during the first 365 days. However, there are a few important exceptions to this private room limitation:

- If your hospital has no semi-private rooms, the plan will pay 90% of the private room charge.

Hospital care (continued)

- If a doctor determines that your condition requires a sterile environment to keep you from contracting an infection or spreading infection, the plan will cover the full private room rate.
- If a sterile environment is required due to impairment of the immunological system (for example, after chemotherapy), the full private room rate will be covered. There must be medical documentation to prove medical necessity for the isolation room.

Intensive Care. If you are confined in the hospital's intensive care unit (that is, one that provides care for critically ill patients other than normal post-operative recovery care), you can receive up to double the plan's daily room and board benefits.

The plan also pays up to $20 for professional ambulance service to the hospital.

Hospital Defined. Hospital charges are only covered when you're confined in a legally constituted and operated institution which has, on its premises, organized facilities for the care and treatment of sick or injured people. These facilities must be supervised by a staff of legally qualified physicians and must have a registered professional nurse on duty at all times. Charges will *not* be considered covered hospital charges if treatment takes place in any institution — or any part of an institution — that

- is used principally as a rest or nursing facility
- is used principally for care of the aged, chronically ill, convalescents, drug addicts or alcoholics (except as described on page 38)
- primarily provides custodial, educational or rehabilitory care.

Pre-Admission Testing

Hospitals routinely require a number of tests before they will start any treatment. But it's usually not medically necessary to perform these pre-admission tests while you're an inpatient. So, whenever possible, arrange to do your pre-admission testing (PAT) as an outpatient or through an approved independent laboratory.

By using PAT, you can shorten your hospital stay by one or two days — allowing you to carry on with your normal routine at home or at work.

Hospital care (continued)

All reasonable and customary PAT charges will be paid at the 100% rate under the Basic portion of the plan provided

- you are hospitalized within 7 days after the tests are performed, and
- the tests are normally required and accepted by the hospital in place of tests that would otherwise have been performed after admission.

Friday/Saturday Admissions

In many cases, hospital admissions on a Friday or Saturday are good for filling empty hospital beds — and not much else. That's because tests and other medical procedures generally are not performed on those days.

Therefore, the plan will not pay hospital charges for a Friday or Saturday admission *unless*

- you're admitted for childbirth or a medical emergency,
- you're admitted to an approved alcohol or drug rehabilitation facility (as defined on page 38), or
- treatment is actually performed on the Friday or Saturday, as certified by the hospital and attending physician.

$ $ SAVE $ $

If you're admitted on a Friday or Saturday, you get *no* hospital benefits for those days (except in the three circumstances listed above). You will, however, receive the regular benefits for the remainder of your confinement.

If you're admitted on any other day, you get *regular plan benefits.*

Home health care/extended care

The previous pages describe the benefits available while you're in the hospital. However, there may come a time when you're well enough to leave the hospital, but not well enough to go without some continued care. In this case you may be entitled to home health care or extended care. These benefits are available if

- you were a hospital inpatient due to the same medical condition for at least three days during the 14 days right before extended care begins, and
- your need for home health care or extended care is medically necessary and certified by the licensed physician in charge of your case.

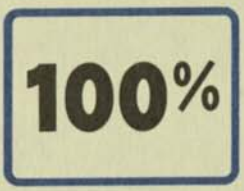
Home health care may be covered if used in place of hospitalization — even if you were not a hospital inpatient before home health care begins.

Home Health Care Benefits

Home health care benefits are available when you are essentially confined to your home and require intermittent nursing, therapy or other services. Services must be provided by an approved Home Health Care Agency and performed by or under the direct supervision of a registered or licensed practical nurse in accordance with a plan or treatment established and periodically reviewed by your physician. A Home Health Care Agency is "approved" if it meets standards set by Medicare.

Covered charges include • services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) • medical and surgical supplies and rental or purchase of durable medical equipment • physical, occupational, speech and respiratory therapy • home health aid services • nutritional guidance • diagnostic services • oxygen and its administration • hemodialysis.

Be sure to check with your Personnel or Employee Relations Office to determine if the durable medical equipment you need will be covered and if it should be rented or purchased.



What Basic Pays. The Basic portion of the plan pays 100% of reasonable and customary covered charges. The maximum benefit per illness is $3,000.

Exclusions. Home health care benefits do *not* cover • custodial care or care of the aged • meals • physician's services • housekeeping services • drugs and biologicals • services performed by relatives or members of your household • care for tuberculosis, alcoholism or drug addiction • care for senility, mental deficiency or retardation • non-medical personal care services.

(Physician's services, drugs and biologicals and care for tuberculosis, alcoholism or drug addiction may be covered under the Major Medical portion of the plan.)

Extended Care Facility Benefits

When you're released from the hospital, your Basic benefits can continue if you still require professional and practical nursing care, you enter an approved Extended Care Facility and you remain under the active medical supervision of a licensed physician. An Extended Care Facility is "approved" if it meets standards set by Medicare.

What Basic Pays. The Basic portion of the plan pays

- 100% of the Extended Care Facility's room and board charges for up to 31 days per confinement — to the extent the charge does not exceed one-half of your hospital's semi-private room rate, and
- 100% of reasonable and customary charges for other medically necessary covered services and supplies during your confinement.

If you leave an Extended Care Facility and are later readmitted, you'll be entitled to another 31 days' benefits *only* if

- at least 90 days have passed since you last left an Extended Care Facility, or
- the medical condition that causes readmission is unrelated to the condition that caused your earlier confinement.

Exclusions. Extended care benefits are *not* payable for • confinement which is principally for custodial care or care of the aged • care for tuberculosis, alcoholism or drug addiction • care for senility, mental deficiency or retardation.

Alcoholism/drug abuse rehabilitation

If you are admitted as an inpatient to an inpatient institution for the treatment of alcoholism or drug abuse, the plan pays benefits just as it would for treatment in a hospital. These benefits are available to you and your dependents — and will only be paid for 45 days per person in a calendar year. Treatment must take place while the patient's health insurance is in effect.

Inpatient treatment for alcoholism or drug abuse must be approved *before admission* through the Pre Admission Review program (PAR). **FAILURE TO GET PAR APPROVAL WILL RESULT IN A 20% REDUCTION IN BENEFITS** (as shown in the example on page 33). For details on how PAR works, please read the special guidebook section marked "PAR."

The benefits will only be paid for two periods of confinement in one person's lifetime. Successive periods of confinement will be considered as one confinement if they are separated by less than seven days.

For this benefit, an inpatient institution means a legally constituted, operated and approved rehabilitation unit licensed by the state or approved by the insurance company. Such facilities provide medical treatment for patients who require inpatient care and have specified medical conditions. They have permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time registered professional nurse (R.N.), and they maintain daily medical records on all patients. **Before admission, please check with the Personnel or Employee Relations Office to make sure the services of the facility you are considering will be covered.**

The Friday/Saturday admission exclusion (see page 35) does *not* apply to admission for treatment of alcoholism or drug abuse.

Surgery

The Basic portion of the plan covers surgery performed by a legally qualified doctor. Benefits are payable no matter where the operation is performed — in

- a hospital*
- doctor's office
- outpatient department of a hospital
- an approved ambulatory surgical facility (sometimes called a "Surgicenter")

The plan pays up to 100% of reasonable and customary charges for each operation.

If you have more than one operation performed through the same incision, or in the same operative area, the plan pays only the reasonable and customary amount for the most expensive procedure. If, during one operation, two or more surgical procedures are performed in different operative areas with separate incisions, you will receive the reasonable and customary amount for the most expensive procedure and 50% of the amount for the other procedures.

Second Opinion Program

An important plan feature helps make sure you have surgery *only if you really need it.* It's called the "second opinion" feature. If you understand how it works and use it properly, you will

- **know the risks and alternatives:** Any surgery involves a degree of risk. A second opinion ensures complete, impartial information on what the risks are and what alternative treatment might be available.
- **make the best decision:** If your doctor's recommendation for surgery is backed up by a specialist, you can be confident that you're doing the best thing for your good health.
- **save money:** If you decide on surgery, the plan pays *more* if you get a required second opinion; it pays considerably *less* if you don't.

Best of all, a required second surgical opinion doesn't cost you a cent. The Company pays the full cost. Here are the details . . .

*REMINDER: If you intend to be hospitalized for your surgery, be sure to get authorization for your admission through the Pre Admission Review program (PAR).

Surgery (continued)

When You Need A Second Opinion. Careful medical studies show that certain surgical procedures often do not need to be performed. In other words, in many cases, the surgical risks outweigh the benefits — or an alternative treatment would be just as effective. These procedures are:

- **Bunionectomy** — removal of bunions
- **Cataract extraction** — removal of lens from eye
- **Cholecystectomy** — removal of gallbladder
- **Coronary Bypass** — open heart surgery
- **Hemorrhoidectomy (Internal)** — removal of internal hemorrhoids
- **Hysterectomy*** — removal of uterus
- **Inguinal Herniorrhaphy** — repair of inguinal hernia
- **Laminectomy/Chemonucleolysis** — removal of intervertebral disc/injection of enzyme into disc space
- **Laparotomy** — exploratory abdominal surgery
- **Ligation and/or Stripping of Varicose Veins** — varicose vein surgery
- **Mastectomy**** — removal of all or part of the breast
- **Meniscectomy** — removal of torn cartilage from knee
- **Oophorectomy** — removal of ovary or ovaries
- **Osteotomy** — large and small bone surgery of foot
- **Prostatectomy** — removal of all or part of the prostate
- **Salpingectomy** — removal of fallopian tube(s)
- **Submucous Resection (Nasal)** — repair of deviated septum of nose (covered only if performed for non-cosmetic reasons)
- **Strabotomy (Tenotomy)** — correction of crossed eyes ("strabismus")
- **Tonsillectomy/Adenoidectomy** — removal of tonsils or adenoids
- **Total knee or hip joint replacement** — replacement of joint with artificial prosthesis

*You do not need a second opinion before dilation and curettage (a "D&C").

**You do not need a second opinion before a breast biopsy.

Surgery (continued)

If your doctor recommends one of the above surgical procedures, **you must get a second surgical opinion through the insurance company's Managed Second Surgical Opinion (MSSO) Review Unit** to get maximum payment from the health plan. The insurance company is The Equitable.

Of course, *in an emergency,* you don't need to get a second opinion — whether or not the surgical procedure is on the list.

REMEMBER: Any doctor, even the best, can recommend surgery that's not really necessary — especially when dealing with a procedure that's not his or her specialty. So be sure to take advantage of the second surgical opinion. It's your guarantee that the surgery you elect is medically in your best interest.

$ $ SAVE $ $

If you get a second opinion for the procedures listed on the previous page, the plan will pay benefits the usual way — that is, 100% of the reasonable and customary charges for your surgery. If you don't get a second opinion, **the plan pays only 50% of your surgical bill, to the extent it is reasonable and customary.** (The reduction in benefits affects the bill for surgery only — not other related expenses such as hospital room and board.)

You are under no obligation to follow the advice of your second opinion consultant. As long as you go for the required second opinion through The Equitable's second opinion program, you will be entitled to normal plan benefits.

As mentioned earlier, you pay nothing for any required second opinion charges. The Company pays the entire cost. What's more, if the second doctor doesn't agree with your first doctor's recommendation, the plan will even pay for a third opinion through The Equitable's program.

How To Get A Required Second Opinion. Two simple steps are all it takes to get a required second opinion.

- First, call The Equitable's Managed Second Surgical Opinion (MSSO) Unit. **Their toll free number is 1-800-662-2273. (In Pennsylvania, dial 1-800-342-2399.)** Usually, your MSSO reviewer will ask you to choose a doctor from a list of specialists in your area. The reviewer will then schedule an appointment for you. In some cases, the reviewer can determine over the phone that surgery is clearly necessary. If so, you will not be required to go for a second opinion and the plan will still pay the normal benefit.

IMPORTANT: Please substitute this page 41/health REVISED for page 41/health in the HEALTH section. Note corrected Managed Second Surgical Opinion phone number.

Surgery (continued)

- If your reviewer says you must go for a second opinion, tell your original doctor that your health plan requires a second opinion for surgery. Then ask him or her to forward your records and test results (lab, X-ray, etc.) to the second opinion consultant. This is becoming a common request, and your doctor will be happy to cooperate.

Be sure to give your Equitable reviewer your Social Security number plus your policy and branch numbers, as shown on your Health Insurance I.D. card.

If you must cancel or change an appointment that The Equitable has arranged for you, it is important for you to advise The Equitable of the change or cancellation.

You should not bring a claim form to the second opinion consultant. You do not have to pay for this consultation.

> A second opinion is valid for six months. In other words, if you get a second opinion and let more than six months go by before your operation, you will have to get *another* second opinion to qualify for normal plan benefits.

What About Other Surgery? If you're considering surgery that's not on the previous list, we highly recommend that you still get a second opinion — because it may help you avoid unnecessary risks and costs.

To do so, you must arrange to see a specialist of your choice (you cannot use The Equitable's program for a referral). Reasonable and customary charges for the second opinion consultation will be covered under the Major Medical portion of the plan at the 80% rate, after the deductible.

If you don't get a second opinion for surgery that's not on the list, the plan will still pay 100% of reasonable and customary surgical charges (*not* 50%).

Same-Day Surgery

No one likes to be hospitalized for surgery. Most people, and especially children, deal with surgery best when they can get back home to a comfortable, supportive atmosphere as soon as possible.

Therefore, it's fortunate that a great number of all surgical procedures — from simple tonsillectomies to delicate cataract surgery — can be performed in one day *without* hospitalization.

You're encouraged to seek same-day surgery whenever possible, either in a doctor's office, outpatient department of a hospital or an independent facility that specializes in outpatient surgery.

Successive disabilities

Under the hospital and surgical coverage, you can receive the maximum benefits for each separate disability.

However, a hospital confinement or surgical operation is considered a continuation of a prior disability if:

- the cause of the later confinement or operation is related to the previous confinement or operation, or
- you did not return to active work between operations or periods of confinement, or
- for a family member, the later confinement or operation occurs within two months of the previous one.

If successive confinements or operations are considered continuous, all related bills are treated as part of one claim.

X-ray and laboratory examinations

If you require diagnostic X-ray or laboratory examinations because of an illness or injury, the plan pays for such examinations performed in the doctor's office, a laboratory or as an outpatient at a hospital.

The plan will pay up to $100 for X-ray or laboratory examinations in connection with each illness or injury within 12 months of the date you became ill or were injured.

This benefit does not apply for X-ray therapy, eye refractions or dental work. If the examination takes place at a hospital, you can receive this benefit only if benefits are not available under the hospital care portion of the plan.

Generic prescription drugs

Usually, physicians prescribe drugs that carry the manufacturer's "brand name." A brand name drug can be *many times* as expensive as its non-brand name equivalent (called a "generic drug"). Yet there is no difference in quality. The chemical composition of a generic drug is the same as that of its brand name counterpart, and government-required quality control is equally strict.

Generic prescription drugs (continued)

Therefore, you should ask your doctor to prescribe generic drugs whenever possible. If you do, it will save you money.

$ $ SAVE $ $

If you use a generic drug, your claim will be covered under the Basic portion of the plan. That means there is *no deductible,* and reimbursement is at *100% of the reasonable and customary charge.*

Non-generic prescription drugs are covered under the Major Medical portion (see page 45). That means 80% payment after a deductible.

To get 100% payment for a generic drug, your pharmacist must write the word "GENERIC" on the bill and sign it.

Non-prescription ("over-the-counter") drugs are not covered under your health plan.

Outpatient emergency care

If you or one of your family members has an accident or suddenly becomes seriously ill, and receives *emergency medical treatment within 48 hours after the accident or onset of an illness,* the plan will pay all of the following charges for such treatment:

- outpatient medical services and supplies at a hospital;
- doctor's treatment in the hospital or *elsewhere;*
- X-ray or laboratory examinations at a hospital or *elsewhere;*
- professional ambulance charges up to $20.

If the accident or illness is so serious that you must be confined to a hospital, the regular hospital benefits described on page 33 will be paid — provided you get authorization for your hospital stay through the Pre Admission Review program (PAR). If this is not done within the required time after admission, **THERE WILL BE A 20% CUTBACK IN HOSPITAL BENEFITS,** as explained on page 33.

You'll find details about PAR behind the special red guidebook tab.

MAJOR MEDICAL BENEFITS

How Major Medical works

Major Medical is designed to assist you when you have extra medical expenses for a serious or prolonged illness or injury. Usually, your Basic benefits cover most of the bills you receive. But when your expenses exceed your maximum Basic benefits, Major Medical picks up the cost (except in the case of home health care or extended care). If you have family coverage, each of your family members is entitled to separate Major Medical benefits for each illness or injury.

Here's how you can determine when you qualify for Major Medical payments:

- If benefits have been paid to you under the Basic portion of the plan, your remaining covered charges total more than $150 ($300 if you have family coverage), and you have accumulated them within one calendar year, you have a Major Medical claim.
- If you accumulate over $150 ($300 if you have family coverage) of covered charges within one calendar year, none of which are paid by Basic benefits, you have a Major Medical claim.

The deductible

Individual Coverage. Before you can receive Major Medical benefits, you must pay $150 of covered charges which are not paid under the Basic portion of the plan. This $150 deductible must be met anew each calendar year. You can satisfy your $150 deductible with expenses from more than one illness or injury.

The deductible (continued)

Family Coverage. If you have family coverage, the $150 deductible applies separately to each covered person. However, a special rule can limit your family's deductible expenses.

If, during a calendar year, two or more family members incur a total of $300 in covered charges (but not counting more than $150 on account of any one individual), you meet the "family deductible." This means all covered family members become eligible for Major Medical benefits for the rest of the calendar year.

Here's an example of how this special rule helped to limit one family's deductible expenses in one calendar year.

Family Member	Covered Charges
Spouse	$ 90
Child	$130
Employee	$ 80
Total Deductibles:	$300

FAMILY DEDUCTIBLE MET

At this point, all covered family members are eligible for Major Medical benefits. No further deductible expenses need be met for the rest of the calendar year.

In determining when the deductible is met, bills are considered in chronological order — based on the date the service is performed.

Family Accident

If, while insured, more than one member of your family is injured in the same accident, only a single $150 deductible applies. You must file a separate Major Medical benefit claim for each person.

How much Major Medical pays

After you have satisfied the deductible for the calendar year, Major Medical pays 80% of most reasonable and customary covered charges. You pay the remaining 20%. Because you share a portion of the expense, this coverage is called *co-insurance.* Doctor's charges for outpatient psychiatric services and alcoholism and drug abuse treatment are covered at a 50% rate — as explained later.

There is *no dollar limit* on how much the plan will pay under Major Medical.

Special Full Payment Feature

Generally, the 20% share of covered charges comes to an amount most people can handle comfortably. However, in cases of serious or prolonged illness, that 20% share could seriously threaten income or savings.

So the plan has this valuable full payment provision, commonly called a "stop-loss." If in any calendar year, your out-of-pocket expenses reach $1,500 (or $3,000 if you have family coverage), the plan pays 100% of covered charges for the rest of the calendar year. Out-of-pocket expenses include the deductible and your expenses at the 20% rate.

IMPORTANT: Charges for outpatient psychiatric services, alcoholism and drug abuse, as detailed in the next section, charges above the reasonable and customary amount or charges not considered medically necessary, will not be used to satisfy the stop-loss, and won't be subject to the 100% reimbursement.

Also, any charges that are not covered because

- you did not use the Pre Admission Review program (PAR) to get authorization for hospitalization (see page 33), or
- you failed to get a required second surgical opinion (see page 39)

will not count toward meeting the stop-loss. Nor will any of those charges be reimbursed *even if you already met the stop-loss.*

Doctor's charges:
psychiatric services, alcoholism and drug abuse treatment

- **Inpatient Care:** For alcoholism, drug addiction, or mental and nervous disorders that are treated in the hospital, while confined, Major Medical pays at the regular 80% level for covered expenses.
- **Outpatient Care:** You will be reimbursed 50% of reasonable and customary charges — up to a maximum covered benefit of $1,500 per year for
  - — professional psychiatric visits in a doctor's office or elsewhere when *not* confined to a hospital, if provided by a **legally qualified physician (M.D.) or licensed clinical psychologist (Ph.D.)**
  - — alcoholism and drug abuse treatment when *not* confined to a hospital or approved rehabilitation facility, if provided by a **legally qualified physician (M.D.) or licensed clinical psychologist (Ph.D.)**

Counseling by a marriage/family counselor, psychiatric social worker or other mental health professional (except as stated above) will **not** be covered.

Hospice care

Nothing causes more physical, emotional and financial stress than having to deal with terminal illness. For this reason, your health plan includes special benefits for "hospice services." Hospice services are designed to meet the exceptional needs of a terminally ill patient and his or her family.

When Benefits Are Payable

Hospice benefits are payable when

- the patient's attending physician certifies that you or a dependent covered under the plan is expected to live less than six months, and
- the patient enters an approved hospice program. A hospice program is "approved" if it meets standards set by the insurance company.

Hospice care (continued)

If you're considering a hospice program, be sure to contact your Personnel or Employee Relations Office. They will check with the insurance company to see if the program is approved.

What Is Covered

Care through a hospice program may be provided on an inpatient or outpatient basis. For example, care in a specialized hospice facility, hospital or at home may all be covered.

During The Patient's Lifetime. The following services are covered during the patient's lifetime — if considered medically necessary by the patient's attending physician, approved by the insurance company, and billed through a hospice program:

- Room and board expenses in:
  - — a hospice facility located within a hospital, up to the hospital's most common semi-private room and board rate
  - — an approved free-standing, inpatient hospice facility, up to the most common semi-private room and board rate for hospitals in the general area.
- Skilled nursing and home health aid, if performed by a registered graduate nurse or licensed practical nurse.
- Counseling for the patient and other family members who are enrolled in the health plan, if administered by a psychiatrist, psychologist or a member of a state-licensed social services organization. The patient's primary physician must determine that the terminal illness is the direct cause of the need for counseling.
- Homemaker services, if the patient's family is unable to attend to the patient's needs.
- Local ambulance or special transport between the patient's home and the hospice facility.
- Miscellaneous services, such as: medical supplies, drugs and medication, physicians' services and rental or purchase of durable equipment.

Hospice care (continued)

During Bereavement. During the six months following the patient's death, the plan covers up to 12 counseling sessions for family members who are enrolled in the health plan by a psychiatrist, psychologist or a member of a state-licensed social services organization.

What The Plan Pays

The Major Medical portion of the plan pays 80% of the reasonable and customary covered charges explained above — after the patient's deductible has been met.

The maximum benefit payable for all covered hospice charges is $10,000. Any benefits payable under other areas of the medical plan are not included in this maximum.

What Is Not Covered

The plan does not pay benefits for the following services or treatments under the hospice care program:

- Volunteer services or other services that would normally be provided free of charge.
- Legal and/or financial advice services (such as, preparation and execution of a will, estate planning and liquidation, financial investment).
- Counseling by the clergy or any volunteer group.
- Services of a person who ordinarily resides in the home of the patient or a member of his or her family or spouse's family.
- Services not provided and billed through the hospice program and not approved by the patient's attending physician and the insurance company.

Other covered charges

When you require treatment for an illness, pregnancy or an accident, Major Medical covers 80% of *reasonable and customary charges* for all of the services and supplies listed below that are medically necessary and prescribed by a legally qualified doctor.

- Hospital expenses for room and board (up to the most common semi-private room rate) and miscellaneous services not covered under the Basic portion of the plan. If your hospital does not have semi-private rooms, 90% of the private room rate will be considered a covered charge. (Remember: regular coverage is contingent upon proper utilization of PAR — the Pre Admission Review program.)
- Doctors' charges in connection with hospital confinements and office visits which are not related to hospital confinements (other than routine physicals).
- Assistant surgeon's charges of up to 20% of the reasonable and customary charges for the surgical procedure.
- Anesthesiologist's charges — up to the reasonable and customary charge.

- The services of a registered nurse (R.N.) — or licensed practical nurse, if an R.N. is not available — except one who is a member of your family or who ordinarily lives in your home.
- Medications which require a physician's written prescription and which must be dispensed by a licensed pharmacist or physician. (Remember: Generic drugs can be reimbursed at 100%, with no deductible. See page 43 for details.)
- Diagnostic X-ray and laboratory services.
- X-ray, radium and radioactive isotope therapy.
- Anesthesia and oxygen.
- Rental or purchase of a wheelchair, hospital-type bed, iron lung and certain other durable medical equipment. **Be sure to have the Personnel or Employee Relations Office check beforehand if the equipment you need will be covered and if it should be rented or purchased.**
- Initial cost of braces, artificial limbs or eyes. (Replacement costs will be paid only if the replacement is medically required.)
- Local professional ambulance service, when medically necessary.

Other covered charges (continued)

- Public transportation, as follows:
  - — to a local hospital for specialized treatment and back to your home
  - — to a specialized hospital or clinic and back to your home when a local hospital cannot provide the necessary care recommended by a physician
  - — from the place where disability occurs to the nearest hospital qualified to provide treatment
- Dental work or cosmetic surgery required as a result of accidental bodily injury which occurs while you are covered under the plan.
- Speech therapy by a qualified speech therapist for speech loss or impairment which results from an injury or sickness — not from a functional nervous disorder or congenital defect.
- Cardiac rehabilitation provided in an approved cardiac rehabilitation program when the program is rendered by a qualified hospital or extended care facility under the direction of a physician. **Be sure to check with your Personnel or Employee Relations Office to make sure that the program you are considering will be covered.**
- The following oral surgery procedures will be covered by the health plan:

  — removal of cysts of the jaw
  — stomatoplasty
  — osteotomy

  Certain other oral surgical procedures may be covered under the health plan. **If you have any questions about coverage of oral surgery under this plan, contact your Personnel or Employee Relations Office.**
- Physical therapy services falling within the guidelines established by the insurance company.
- Chiropractic services, up to:

  — 25 visits in the first 90 days
  — 12 visits in the next 60 days
  — 10 visits thereafter

What's not covered

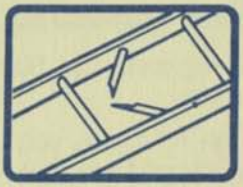
The Basic/Major Plan does not cover expenses for any of the following:

- Sickness or injury that is not treated by a legally qualified and licensed physician or surgeon
- Routine physical examinations
- Private nursing care by a member of your family
- If you occupy a private hospital room, charges in excess of the hospital's most common semi-private room charge (except as described on pages 33 and 34)
- Care or treatment in a government-owned or operated hospital
- Expenses that you are not legally required to pay
- Sickness or injury resulting from war or an act of war, or incurred while in the armed forces
- Any days of hospital confinement or any medical services which are not medically necessary
- Experimental medical treatment, therapy or surgery
- Drugs and medicines not approved by the FDA (Federal Drug Administration)
- Any charges resulting from injury or sickness connected with employment with any employer
- Eye refractions, optic training, eyeglasses, contact lenses, hearing aids or examinations for their prescription or fitting
- Care or treatment in other than a legally constituted and operated hospital as defined on page 34
- Care or treatment in any institution or part of an institution which is primarily a rest facility, nursing facility or facility for the aged, chronically ill, convalescents, drug addicts or alcoholics; also, one primarily engaged in custodial, educational or rehabilitory care — except as defined on page 38
- Drainage of an intraoral alveolar abscess, acute with cellulitis
- Dental work, treatment or appliances other than required as a result of accidental bodily injury or other than certain oral surgical procedures
- Exercise bicycles, whirlpools, treadmill joggers, environmental control equipment or other non-medical equipment

What's not covered (continued)

- Cardiac rehabilitation that is *not* provided in an approved cardiac rehabilitation program and rendered by a qualified hospital or extended care facility under the direction of a physician

IMPORTANT: See "Other Important Facts" on page 58 for other conditions that may affect this coverage.



Example: Basic and Major Medical

An employee is severely injured in an accident. He is confined in a hospital for 20 days requiring surgery and private duty nursing, as well as extensive treatment after his discharge. The employee obtained authorization for hospitalization through the Pre Admission Review program (PAR) within the required time after hospitalization. Here is how his bills were covered.

	Total Charges	Paid by Basic Medical*	Expenses Toward Major Medical*
Hospital Semi-Private Room Charges — 20 Days at $150 per Day	$3,000	$3,000	$ 0
Miscellaneous Hospital Charges	$4,100	$4,100	$ 0
Surgeon's Fee	$ 950	$ 950	$ 0
Anesthetist's Fee	$ 180	$ 180	$ 0
Private Duty Nursing	$1,000	$ 0	$1,000
X-ray and Laboratory Fees After Discharge From Hospital	$ 150	$ 100	$ 50
Prescription Drugs After Discharge From Hospital	$ 100	$ 0	$ 100
Doctors' Fees	$ 210	$ 0	$ 210
TOTALS	$9,690	$8,330	$1,360
Less $150 Cash Deductible			– 150
			$1,210
			x 80%
Paid by Major Medical			$ 968

Total Charges	$ 9,690	
Total Paid by Plan	– 9,298	($8,330 Basic + $968 Major)
Employee Pays	$ 392	(Employee's annual cost includes the deductible plus $240 in contributions for individual coverage, or $480 for family coverage.)

*assuming all charges are within the reasonable and customary limits

How The Full Payment Provision Works

If you incur covered expenses under Major Medical that total $6,900, you pay the $150 deductible plus 20% of the remaining $6,750 (20% x $6,750 = $1,350). In total, you've paid $1,500 in covered charges. Under the special full payment provision, the plan would then pick up 100% of your covered charges over $6,900. In other words, no matter what your covered charges

Example: Basic and Major Medical (continued)

totalled, you would end up paying no more than $1,500 in covered charges in any calendar year.

Please be sure to read pages 58 through 74. There, you'll find more important facts about the Basic/Major Plan.

HEALTH MAINTENANCE ORGANIZATIONS

If there are Health Maintenance Organizations (HMOs) in your community, one or more may be offered to you as a substitute for the Company's health plan (Comprehensive or Basic/Major).

HMOs coordinate the services of physicians and specialists in an attempt to provide a wide range of medical care services economically.

Some HMOs operate as *group practices.* In these instances, several doctors are grouped together in one clinic or medical center, and the doctors share common laboratory, diagnostic and surgical facilities. Other HMOs are *individual practices.* In these cases, several doctors are associated with one another and/or with a hospital, but each doctor has a separate office.

Generally, an HMO requires that you visit only local HMO-approved doctors and hospitals to obtain medical treatment, except in certain emergency situations. This restriction may be an important factor to consider in deciding whether or not to join an HMO.

The Cost

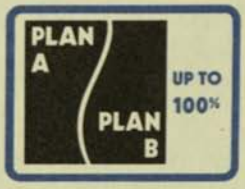
Most HMOs provide services for a fixed monthly fee, which is paid in advance. If you and your family members are eligible to participate in the Company's health plan, you can enroll in any HMO offered to you. If you do, the Company will help you meet the monthly HMO charge. The Company will contribute the same amount that it would otherwise pay for your Company health insurance or the HMO charge, whichever is less. If the monthly HMO charge is greater than the Company contribution, the balance will be made up automatically through payroll deductions.

If you decide to participate in an HMO and later decide to join the Company's health plan, you will have to wait for an open enrollment period. There is one open enrollment period each year.

Only you can decide if enrollment in a particular HMO is worthwhile. When you are offered the HMO option, the Company will give you a detailed comparison outlining the differences between HMO coverage and coverage under the Company's health plan. You should study this comparison carefully and, if possible, visit the HMO to ask questions. Think seriously about your health care needs before you make your decision. This will help you determine which coverage is most appropriate for you.

OTHER IMPORTANT FACTS: BOTH PLANS

The following important facts apply to both the Comprehensive Plan and the Basic/Major Plan.



Coordination of benefits

The coordination of benefits features explained in this section apply to active employees. Coordination with Medicare for retirees works differently.

Since many companies make health insurance benefits available to their employees, some of you may now be covered by more than one group plan. This situation arises when both you and your spouse are employed, and both of you are covered under your employer's group plan. As a result, you could receive payments in excess of your actual expenses.

To avoid such duplicate payments, our plans contain what is known as a "coordination of benefits" (COB) provision. If you or one of your family members is covered by other group insurance or similar coverage, your Company health plan will coordinate its benefit payments with your other coverage — including no-fault motor vehicle coverage — so that you will receive no more than 100% payment for the allowable medical charges.

Here is how COB works. If you or a dependent is covered under more than one group plan, you should determine which plan pays benefits first (this is called the "primary" plan). Claims should be submitted to the primary plan first. After the primary plan has paid benefits within its limits, a claim can be submitted to the other plan. The other plan will then determine what remaining charges it will cover.

Here are the general rules used by most insurance companies to determine which plan is primary.

If you are covered by another plan that doesn't have a coordination of benefits provision, the other plan has the primary responsibility for paying claims. If both plans under which you're covered have a coordination of benefits provision, the following factors determine which plan pays first:

- a plan which insures the person as an employee pays before a plan which insures the person as a dependent

Coordination of benefits (continued)

- for children, the plan which insures the father pays first
- a plan which insures the person as an active employee pays before a plan which insures the person as a retiree

If a person has two coverages through two jobs, the plan which has insured the person for a longer period of time pays first.

If you're divorced or legally separated, other factors are considered. The plan of the parent who has custody of the children pays first, a step-parent's plan pays second and the plan of a natural parent who doesn't have custody pays third. If a court decision has established financial responsibility for the children, the plan of the parent with financial responsibility pays first, the step-parent's plan pays second and the other natural parent's plan pays third.

No-fault motor vehicle coverage will be the primary payor of benefits regardless of the above guidelines — except in those states which require otherwise.

These coordination of benefits provisions do not apply to any *individual* policy you may have.

If you or a dependent has dual coverage, the person who handles medical claims at your location can help you determine which plan is primary. This will help speed up processing of your claim.

Credit Reserve

Through coordination of benefits, your plan sometimes pays less than it would have if you had no other coverage. In such cases, the difference between what your plan actually paid and what it would have paid becomes your *credit reserve*. The insurance company will use the credit toward any additional expenses that you incur during the year. However, the insurance company will not carry the credit over to the next year.

Example. Suppose that your wife is a covered dependent under the Basic/Major Plan. She is hospitalized and requires surgery for some knee damage after a fall. She is also employed and covered by group insurance where she works. Her plan pays first in this case.

Coordination of benefits (continued)

	Total Charges	If No Other Insurance, Our Plan Would Pay	Since the Other Plan Paid	Our Plan Only Paid
Hospital Semi-Private Charges — 5 Days at $50 per Day	$ 750	$ 750	$ 450	$300
Miscellaneous Hospital Charges	$ 500	$ 500	$ 300	$200
Surgeon's Fee	$ 480	$ 480	$ 200	$280
Anesthetist's Fee	$ 100	$ 100	$ 60	$ 40
Other Doctors' Charges (Major Medical at 80%)	$ 50	$ 40*	$ 30	$ 20
	$1,880	$1,870	$1,040	$840

*the example assumes that the deductible has already been met

As you can see, with total charges of $1,880, you and your wife would have had NO OUT-OF-POCKET EXPENSES for this claim. Since your wife's group insurance plan paid $1,040, our Basic/Major Plan then paid the difference of $840. In addition, you have a $1,030 credit reserve under your plan ($1,870 — $840 = $1,030).

How to file a claim

When you have a medical claim, you may obtain a claim form from your Personnel or Employee Relations Office.

Completing A Claim Form. You should file your first claim each calendar year after you've accumulated enough bills to meet the deductible. On the form . . .

1. Fill in all items under "Employee's Statement." (Leave "Employer's Statement" blank.) Pay particular attention to items 5, 5a, 6 and 6a regarding dependents and other group insurance coverage.
2. For item 8, under the *Employee's Statement,* always enter *your* (employee's) Social Security number — even if the claim is for a spouse or child. Your claims cannot be processed without your correct Social Security number.
3. *Always* complete the authorization to release medical information.
4. In case of a hospital claim, the hospital must attach an itemized bill to the claim form. If non-hospital, the physician must complete the "Medical/Surgical" portion *OR* attach an itemized bill to the claim form.

An ITEMIZED BILL Must Show

- to whom it applies (you or dependent)
- date of service
- diagnosis
- treatment performed
- amount charged
- name, address and phone number of provider of service

INCOMPLETE BILLS WILL NOT BE PROCESSED

IF FAMILY COVERAGE: FILE A *SEPARATE* CLAIM FOR EACH COVERED DEPENDENT ALONG WITH HIS OR HER ITEMIZED BILLS.

Later Bills. Say you already have a claim form on file for the calendar year. When you get another bill, here's what you do . . .

1. *If you've paid the bill* and want the insurance company to *reimburse YOU:* You *don't* have to submit another claim form. Just give an itemized bill to your claims person.

How to file a claim (continued)

Exceptions: A new claim form is *always* needed

- when bills relate to an accident
- when information on your last form is outdated (for example, if you get married or if a dependent gains or loses other group health insurance)

2. If you want the insurance company to *pay the PROVIDER OF SERVICE* (doctor, hospital, etc): You must submit a new claim form. Be sure to sign the section that authorizes payment to the provider of service. (This is called an "assignment of benefits.") The provider's tax I.D. number must appear on the claim form.

   If you want to cancel an assignment of benefits, you must submit proof that you've paid the outstanding bill in full.

Important Tips. Here are some other important points about filing claims.

1. Don't submit cancelled checks, cash register receipts, balance due statements, non-itemized bills or photocopies. THEY ARE NOT ACCEPTABLE AS PROOF OF EXPENSES. (Exception: a photocopy is OK if our insurer is the secondary payor of benefits.)
2. Part of a dependent's claim may be paid first by his or her own group insurance. If so, you must attach the other insurer's "Explanation of Benefits" to your secondary claim.
3. If the insurance company requests additional information to consider payment of a claim, it is *your* responsibility to obtain and submit the requested information.

   Incomplete or incorrect claim forms/bills will be returned to you and will delay processing.

How to file a claim (continued)

4. The more detail provided with claim forms/bills, the better. Details (especially operative notes for surgery and a full report on chiropractic services) allow the insurer to process claims quickly and accurately.
5. Claims submitted more than two years after the date of treatment WILL NOT BE PAID.

Keep A Copy Of Everything For Your Personal Files.

Direct All Questions To Your Company Claims Person — Not The Insurance Company.

If your claim isn't paid within 90 days of the date you returned the completed forms (or within 180 days if you were told there would be a delay), see the person who handles insurance claims at your location.

Procedure For Appealing Claims

If your claim is denied, in whole or in part, the insurance company will provide you with a written notice within 90 days from the date they received your claim (or 180 days if they notified you that there would be a delay). The notice will explain the reason(s) for the denial, point out the part of the plan on which the denial is based, and outline the steps you must take to appeal the denial. If you've made an error in your claim, the notice will list ways you can correct it.

You are entitled to appeal a claim that is denied within 60 days of the date you received the denial notice. To do so, write to the person who sent you the denial notice. Be sure to state why you believe the claim should not have been denied, and submit any additional information you feel may be relevant.

You will receive a written decision on your appeal within 60 days of the time the insurance company received your request. Under special circumstances (e.g., to hold a hearing), it may take longer than 60 days to reach a decision. In that case, you'll receive written notification of the delay within 60 days.

If you become disabled

If you become totally disabled, your health insurance will continue. If you had family coverage at the time of your disability, your dependents will also be covered while they meet the definition of an eligible dependent. You pay nothing for this extra protection unless you're receiving full pay from a Company-provided salary continuance program. Here is how long coverage lasts:

First Six Months. During your first six months of total disability, coverage will continue under the plan which was in effect immediately prior to your disability.

Next Two Years. Starting with your seventh month of disability, coverage will continue for two more years under the Comprehensive Plan — provided you remain totally disabled. (Basic/Major Plan coverage is not available.)

Extended Protection. If you are still totally disabled after 2½ years, coverage for you and any eligible dependents will continue under the Comprehensive Plan if

- you have at least 15 years of service (counting your first 2½ years of disability) and
- you are receiving benefits under the Company's Long-Term Disability Plan.

Coverage under the Comprehensive Plan will continue until you recover or retire — whichever happens first. At retirement, you will be eligible for retiree health coverage.

A different rule applies if you have been totally disabled for 2½ years and do not meet the two eligibility requirements for the extended protection described above. In that case, you will have *limited coverage* under the Comprehensive Plan. "Limited coverage" means the Comprehensive Plan will only pay benefits for covered charges that are incurred *directly because of the disabling illness or injury.* Limited coverage ends on the *earliest* of the following dates:

- the date you recover
- the date you become eligible for similar coverage under another group insurance plan, or
- the end of the calendar year following the year in which your regular Comprehensive Plan coverage ended.

If you become disabled (continued)

Disabled Dependents

If a dependent becomes totally disabled, his or her regular coverage continues until your coverage ends — or until he or she no longer meets the definition of an eligible dependent. However, special *limited coverage* can continue even beyond the date when regular coverage ends.

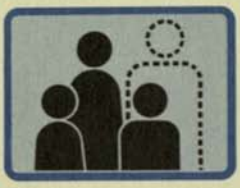
If a totally disabled dependent is in the Basic/Major Plan immediately before regular coverage ends, limited coverage under the Basic portion of the plan is provided for three months past the date regular coverage ended. Limited coverage under the Major Medical portion of the plan is provided until the end of the calendar year following the year in which regular coverage ended.

If a totally disabled dependent is in the Comprehensive Plan immediately before regular coverage ends, limited coverage is provided until the end of the calendar year following the year in which regular coverage ended.

"Limited coverage" means coverage only for covered charges that are incurred *directly because of the disabling injury or illness.* Limited coverage ends immediately if the dependent is no longer totally disabled — or if he or she becomes eligible for similar coverage under another group insurance plan.

Total Disability

For purposes of determining continued health coverage during disability, a person is considered "totally disabled" if he or she is unable to engage in any occupation for compensation or profit, or perform any activities which are usual for his or her age.



If you should die

If you die while actively employed, your eligible enrolled dependents' coverage will continue under the Comprehensive Plan for three months. Coverage under the Basic/Major Plan is not available — even if you were covered under the Basic/Major Plan before death.

There is no charge for this extra protection. However, coverage may continue longer than three months in the two situations described next.

If You Have Family Survivors' Coverage. If you die in active service and you . . .

- were enrolled for Family Survivors' Benefit coverage under the pension plan
- had 10 years of service, and
- were enrolled for family coverage under the health plan

. . .your eligible dependents will have extended Comprehensive Plan health insurance. Coverage for your spouse will continue for as long as he or she lives. Coverage for your eligible children continues until their Family Survivors' Benefit stops (provided, however, that for this purpose coverage will stop no later than age 25).

If You Die After Age 65. If you die in active service after age 65 and you . . .

- were in the pension plan
- were enrolled for family health coverage

. . . coverage for your spouse under the Comprehensive Plan will continue for his or her lifetime at no cost. Your eligible dependent children's coverage will continue until they are no longer eligible dependents.

When coverage ends

Your insurance coverage ends when you leave the Company, become ineligible or the group policy terminates, whichever happens first. Your dependents' coverage ends when yours does or when a dependent is no longer eligible.

If you are laid off or on an approved leave of absence, you may continue your coverage under the plan you were enrolled in at the time of layoff or leave. To do so, you must pay the full cost of the premium. Your coverage may be extended through the third month after the month you stopped active service.

If The Group Insurance Policy Terminates

If the group insurance policy terminates, or if it is amended to end coverage for the group of employees that you belong to, you won't receive benefits for any expenses that you incur on or after the termination date. This includes the limited coverage provided in case of disability as described on pages 64 and 65.

Conversion privilege

If you have been insured for at least three months, you can convert your health insurance to an available individual policy. You need not undergo a medical examination, provided that you apply within 31 days after your insurance terminates. Of course, you will pay the entire premium for this individual policy, and the benefits will be substantially different from those described in this section.

The conversion privilege is available to your covered family members in the event of your death while you are insured. It is also available to your dependent children who reach the maximum age for coverage under this plan, and to a spouse upon divorce.

See your Personnel or Employee Relations Office for conversion information.

Post-65 coverage —active employees

If you remain in active service beyond age 65 (the age when Medicare coverage starts), your health insurance will automatically continue under the Comprehensive or Basic/Major Plan (whichever you had before 65) as your *primary coverage.* In other words, you will be covered the same as any other active employee under age 65. Medicare will provide limited supplementary coverage. However, the Company *will not* reimburse you for your participation in Part B of Medicare. This arrangement will continue until you retire or reach age 70 — whichever happens first.

If you prefer, you can elect *not* to participate in either Company group health insurance plan after age 65. Medicare will be your *primary and only* payor of medical benefits. However, the Company *will* reimburse you for your participation in Part B of Medicare.

If your spouse is age 65 or older, he or she will also have primary coverage under the Company plan (with Medicare for supplementary coverage) — unless you elect otherwise.

If you're still an active employee when you reach age 70, Medicare automatically becomes the primary payor of benefits. Your Company plan will be secondary. So be sure to apply for Medicare in time for coverage to take effect no later than your 70th birthday.

Medical benefits for early retirees (before age 65)

If you retire between ages 55 and 65, your medical benefits can continue under the Comprehensive Plan just as if you were an active employee. Coverage under the Basic/Major Plan is not available — even if you had Basic/Major coverage before retirement. To be eligible for continued coverage under the Comprehensive Plan you must

- have 15 years of eligibility service, as defined in the pension section, and
- be receiving pension benefits (or have received a lump-sum distribution of your entire pension).

Your eligible dependents will also be covered, provided you had family coverage immediately before retirement. You pay nothing for this extended protection.

Once you reach age 65, your health benefits will be coordinated with Medicare. This means your claims go to Medicare first. Any expenses not paid by Medicare will then be considered under your Company plan.

If you die after retirement while you are covered under a Company health plan, your spouse's coverage will continue for life at no cost. Your children's coverage will continue until they are no longer eligible dependents.

Post-65 retiree medical benefits

If you retire at age 65 or later, you will be covered under the Comprehensive Plan at no cost to you. Your eligible dependents will be covered, too, provided you had family coverage immediately before retirement. Coverage under the Basic/Major Plan is not available — even if you had Basic/Major coverage before retirement. As soon as you retire, your benefits will be coordinated with Medicare.

After your death, coverage for your spouse will continue for his or her lifetime, at no cost. Your children's coverage will continue until they are no longer eligible dependents.

Future of the plan

The Company necessarily reserves the right to charge for coverage or to end or amend health coverage for you or your dependents at any time.

Plan administration

A plan administrator is responsible for providing participants with information about their benefits, processing payments, implementing plan changes and handling other functions necessary for the plan's operation. The plan administrator for both the Comprehensive and Basic/Major Plan is North American Philips Corporation, 100 East 42nd Street, New York, N.Y. 10017 (212) 697-3600.

Your Personnel or Employee Relations Office handles plan administration on the local level; they should be your first source for answers to any questions you have about your plan.

Insurance Company

Your benefits are insured by The Equitable Life Assurance Society of the United States, 1285 Avenue of the Americas, New York, N.Y. 100019.

Agent For Service Of Legal Process

For any legal proceedings, the plan's agent is CT Corporation System, 277 Park Avenue, New York, N.Y. 10017.

Legal process may also be served on the plan administrator.

Plan Year

Records for the plan are kept on a calendar year basis ending each December 31.

Employer And Plan Number

The Employer Identification Number (EIN) is 13-1895219 and the Plan Number (PN) is 501.

Plan Cost

The health insurance contract is experience-rated. Employees pay a fixed amount. The Company is responsible for the remaining cost — after any dividends.

Effective Date

This guidebook section is a summary of health plan provisions in effect as of January 1, 1986.

Your rights under law

As a participant in either group health insurance plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other locations (including worksites), all plan documents including copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. (The 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 annual report.

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

Your rights under law (continued)

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 your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

The benefits description in this guidebook section does not constitute an express or implied contract of employment.

1/86

The Equitable Life Assurance Society of the United States

NEW YORK, NEW YORK

CERTIFICATE OF INSURANCE

This is to certify that, subject to the terms of Group Policy(ies) combined for dividends with Group Policy #63601,D,H,M,DE, the salaried employees of the Policyholder named below, are insured for the benefits described in Benefits, below.

NORTH AMERICAN PHILIPS CORPORATION

BENEFITS

The Equitable benefits for which you are insured are set forth in the plan booklet. Insurance takes effect only if you are eligible for it, you elect it and you make contribution for it, as required.

Benefits payable under your medical expense insurance for covered services may be assigned by you to the provider who performed the service.

The Policyholder and the Equitable have agreed to share in the responsibility for the payment of the medical expense insurance as they are set forth in the plan booklet.

This certificate takes the place of any prior one issued to you covering this insurance. It is not the insurance contract; each policy and the Policyholder's application for it are the contract. This certificate is evidence of insurance under the policy(ies). This insurance takes effect only for persons who become and stay insured under each such policy.

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

PF26003(1.2)

73/health

ACCIDENT AND HEALTH INSURANCE

On receipt of due proof of claim, Accident and Health benefits are payable to you. If the policy provides daily benefits you will be paid at the end of each two weeks during the period for which benefits are payable. If there is any balance still due at the end of such period, it will be paid upon receipt of due proof.

NOTICE OF CLAIM. Written notice of the event on which claim is based must be given to the Equitable at its Regional Benefits Office within 20 days after the loss for which claim is made. Late notice will be accepted only if it is furnished as soon as is reasonably possible.

On receipt of such notice, you will be given forms for filing proof of claim. If you have not been given such forms within fifteen days after the receipt of notice, you can fulfill the terms of the policy as to proof of claim by giving written proof of: (i) the occurrence of the loss; (ii) the nature of the loss; and (iii) the extent of the loss.

Such proof must be given within the time stated in "Proof of Claim" below.

PROOF OF CLAIM. Written proof of claim must be given to the Equitable at its Regional Benefits Office on the Equitable's forms within 90 days after the date of loss for which claim is made. Late proof will be accepted only if it is furnished as soon as is reasonably possible. Itemized bills may be required as part of proof of claim.

EXAMINATIONS. The Equitable at its own expense has the right to have a doctor examine any person when it deems it reasonably necessary while there is a claim pending under the policy.

LEGAL ACTIONS. No one may sue for payment of claim less than sixty days after due proof of claim is furnished or more than 2 years after the date proof of claim is required by the policy.

PF26003(3.1)(Amended by PF18505)

PRE ADMISSION REVIEW (PAR)

A Most Important Health Plan Feature

Hospital costs represent the single largest portion of the total national health care bill. And those costs continue to rise at an alarming rate. Clearly, the government, the health care delivery system, companies like ours and individuals like you must work together to prevent hospital costs from becoming too heavy to shoulder.

The Company is doing its part through responsible health plan design. For example, in 1984 we introduced incentives to get second surgical opinions, use pre-admission testing, have same-day surgery, and use cost- and care-effective alternatives to hospitalization (such as home health care and extended care). The Company has now taken another important step forward for the cause of quality health care at affordable cost: Pre Admission Review (PAR) for all hospital admissions.

Basically, each and every time you or a covered dependent is hospitalized, *you must obtain approval for the admission.* In brief, PAR works like this:

- **For non-emergencies,** you and your physician must submit a form to PAR Services (a special division of the health plan's insurer) to get written approval for hospitalization *before admission.* The approval will include the number of hospital days authorized.
- **For urgent admissions,** your physician can call a PAR reviewer to get authorization *before admission* over the phone.
- **For emergencies,** you can receive approval *after admission.* However, your physician or hospital must call PAR Services for approval within 48 hours after admission (or 72 hours on weekends and holidays).
- **For extensions of stay** beyond the number of hospital days originally authorized, your physician must contact PAR *before the extra days begin.*

PAR Services' toll-free telephone number is **800-662-2273.** In Pennsylvania, dial **800-342-2399.**

The Company is convinced that Pre Admission Review is one of the best programs available to promote quality, cost-effective health care. For this reason, we are giving you a *strong dollar incentive* to use PAR:

> If you use PAR, you will receive your regular health plan benefits — as explained in the health plan section of this guidebook. If you don't get proper PAR approval, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%.**

Please be sure to read the following pages with care for details on what PAR can do for you.

Pre admission review (PAR)

When you must use PAR

Pre Admission Review applies to *all hospital admissions for inpatient care,* whether you're in the Comprehensive Plan or the Basic/Major Health Plan. Every time you are hospitalized, you must get authorization for the admission and length of stay through PAR.

What's more, PAR *applies to all your covered dependents exactly the same way as it applies to you.* So please be sure your family knows about this most important health plan feature.

You do *not* use PAR for outpatient care, even if provided in a hospital. For example, if you go to a hospital emergency room (with no subsequent admission) or have same-day surgery in a hospital, there is no need to contact PAR Services.

How to get PAR authorization

PAR has been set up to make the authorization process quick and simple. And you'll never experience a delay in treatment because of the PAR requirement.

Non-Emergency Hospitalization

Usually, you know in advance that you will be hospitalized. So in non-emergency situations, you must get written authorization for inpatient care *before you go into the hospital.* Just follow these simple steps:

- Get a "Request For Pre Admission Review" form from your Personnel or Employee Relations Office. As you can see from the sample form on page 8, it's short and easy to complete.
- Fill out the top part of the form. Have your physician complete the rest, indicating the proposed treatment and length of hospital stay. Your physician should then send the form to PAR Services in the pre-addressed, postage-paid envelope that comes with the form. This should all be done about two weeks before your proposed admission.
- A professional PAR reviewer will evaluate the proposed admission plan for medical necessity and length of stay, based on medical norms as well as any special circumstances relating to your case. For example, a patient's age, general condition and medical complica-

tions will all be considered in determining the approved number of hospital days. If the PAR reviewer has questions about the admission or length of stay, he or she will call your doctor. Your doctor can then discuss your case in more detail with the PAR reviewer.

If admission is approved, the reviewer mails written authorization usually within 24 hours after receiving the request. The approval states the number of authorized hospital days. You, your doctor and hospital will each receive a copy of the PAR approval.

Urgent Admissions

What if your doctor advises you to be hospitalized immediately? If this happens, you must still get PAR approval *before you are admitted.* But in this case, your doctor can call a PAR reviewer directly to get authorization on-the-spot over the phone. Phone authorization will be confirmed in writing usually within 24 hours of the call.

In Case Of Emergency

If you are hospitalized for an emergency, your physician or hospital administrator can get PAR approval by phone *after admission.* However, the call must be made

- within 48 hours of admission on weekdays, or
- within 72 hours of admission on weekends and holidays.

Authorization by phone will be confirmed in writing usually within 24 hours of the call. This special emergency procedure has been set up to prevent any delay in treatment.

To Call PAR Services

If you do not receive a copy of the PAR approval within a week or so after it was mailed (or if you want to be sure your doctor submitted the form), you can call PAR Services directly yourself. Of course, you're also free to call PAR Services if you have any other questions.

PAR Services' toll-free telephone number is 800-662-2273. In Pennsylvania, dial 800-342-2399.

Calls can be made on weekdays between 9 A.M. and 8 P.M. Eastern Standard Time.

IMPORTANT: If your physician recommends that you stay in the hospital beyond the number of days originally authorized, he or she must call your PAR reviewer *before those extra days begin.* Unless the extra days are pre-authorized or found to be medically necessary, the 20% cutback in hospital benefits will apply to the extra days.

If you don't use PAR

If you don't get proper PAR approval for any hospitalization, **THE BENEFITS YOU WOULD ORDINARILY RECEIVE FOR HOSPITAL CHARGES WILL BE REDUCED BY 20%.**

For example, assume you have individual coverage under a Company-provided health plan and you are admitted to a hospital. Your hospital charges come to $5,000. These numbers will show just how important it is to use PAR.

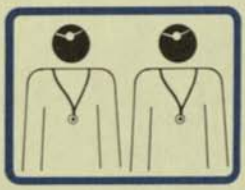
Health Plan	With PAR	Without PAR	Reduction In Benefits
Comprehensive	$4,080 (85% of hospital charges, after $200 deductible)	$3,264 ($4,080 reduced by 20%)	$816
Basic/Major	$5,000 (100% of hospital charges, no deductible)	$4,000 ($5,000 reduced by 20%)	$1,000

PLEASE NOTE: Any benefits lost by not using PAR cannot be regained through your health plan's special full-payment (or "stop-loss") feature. (The Comprehensive Plan's stop-loss is explained on page 10/health; the Basic/Major Plan's stop-loss is explained on page 47/health. In other words, any hospital charges that are not covered because you failed to use PAR *will not count toward meeting the stop-loss.* And those charges will not be paid *even if you have already met the stop-loss.*

How PAR helps you

The best thing about PAR is that it gives you added assurance that the hospital is the best place to be for your particular condition. And it lets you know *in advance* that your hospital stay is medically necessary.

Also, your PAR reviewer will be familiar with your health plan. This way, he or she can remind you about other important plan features. For example, your reviewer might help you



- **remember to get a required second surgical opinion,** to avoid a reduction in benefits for surgery. In fact, your health plan's Managed Second Surgical Opinion program (explained in the health section of this guidebook) is administered by the PAR staff.
- **cut down on hospital days** through pre-admission review
- **avoid a Friday or Saturday admission,** which is usually not covered by your health plan
- **consider same-day surgery** for 100% reimbursement
- **opt for medically-sound alternatives to hospitalization** — such as home health care or extended care.

In short, the PAR reviewer can help you get quality, cost-effective care. At the same time, his or her advice can help you *save money* on health care costs.

The PAR reviewer

The PAR review is performed by a registered nurse who has years of hands-on hospital experience, as well as specialized training in the review process. The reviewers know the ins and outs of hospital admissions, benefit coverage and review procedures. Also, the reviewers are backed by a network of consulting physicians who offer expert advice whenever needed.

Two special PAR features

There are two more special services that come to you as part of PAR.

Psychiatric Consultation Services

Psychiatric Consultation Services (PCS) is a program designed to ensure quality care for patients confined to a hospital or other facility because of mental and nervous disorders or for alcoholism or drug dependence. PCS works along with Pre Admission Review to make sure that the time spent in the hospital or other facility is medically necessary and that the treatment site is the most appropriate.

When you (or a dependent) are admitted to a hospital or other specialized facility for psychiatric, alcoholism or drug dependency care, you must use PAR — just as for any other hospital admission. When PAR is notified of this type of admission, the reviewer refers the case to the PCS staff. A member of the PCS consulting team then contacts the patient's physician to review the reason for the confinement, the ability of the facility to provide the level of care the patient needs, and the treatment plan and goals. During the patient's stay, the PCS team continues to consult with the physician — monitoring the patient's progress and encouraging early discharge planning. In this way, PCS helps the patient get the targeted care needed to speed recovery and reduce the length of confinement.

The PCS consulting team includes board-certified psychiatrists, doctoral level psychologists, licensed psychiatric social workers and certified alcohol and substance abuse counselors. They work with the patient's attending physician on a professional-to-professional basis to see that the patient gets the most appropriate and medically necessary care.

Medical Case Management

Along with catastrophic illness or injury come a bewildering array of problems and concerns. Am I getting the best possible care? Is the hospital the right place to be? Where can my family and I turn for counseling and support? Medical Case Management (MCM), a special part of PAR, has been set up to address such questions.

Two special PAR features (continued)

Medical Case Management may step in when you or a covered dependent is affected by one of the following illnesses or injuries:

Illnesses

- Neonatal High Risk Infant
- Cerebral Vascular Accident (CVA, or severe stroke)
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig disease)
- Acquired Immune Deficiency Syndrome (AIDS)

Injuries

- Major Head Trauma
- Spinal Cord Injury
- Amputations
- Multiple Fractures
- Severe Burns

If the insurance company accepts a patient for medical case management, an expert MCM coordinator is assigned to the case. The coordinator works closely with the patient, family and attending physician to

- *assess the patient's condition.* The coordinator prepares a medical evaluation and suggested treatment plan based on input from the attending physician and, if need be, from an outside medical consultant.
- *act as an information resource.* Through a national network of information sources, the coordinator can recommend quality, cost-effective facilities and services that are most appropriate for the particular patient.
- *monitor the patient's progress.* The coordinator follows the patient's progress to assure the appropriateness of care and help the patient achieve greater independence (for example, through home health care).
- *provide ongoing support.* Throughout the treatment period, the coordinator is an important source of information on support services that the patient and family may need — such as community programs and counseling.

In addition, at the MCM coordinator's recommendation, the health plan may cover certain medical services and supplies that ordinarily would not be covered.

In short, the MCM coordinator's role is to provide the facts, suggestions and support needed to make the best decisions regarding the patient's care. Of course, any final decision on the actual course of treatment is left up to the patient, family and attending physician.

Your health I.D. card

You will receive a health I.D. card with a capsule summary of your health plan. The card also indicates the Pre Admission Review requirement and gives PAR Services' telephone number. *You should carry the I.D. card with you at all times.* It serves as a valuable reminder about PAR for you, your doctor or hospital. Extra I.D. cards are available for your dependents.

REMEMBER: Since all PAR features apply equally to you and your covered dependents, be sure your family knows all about PAR. That way, you can help remind each other about this most important plan feature when any family member needs to be hospitalized. This can be especially vital in case of an emergency — when the patient may not be able to tell the doctor to call PAR.

Filing a claim

Whenever you file a claim form that includes any hospital charges, you should attach the PAR authorization notice.

The PAR program is designed to assure the medical necessity of hospital admissions and length of stay. A PAR hospital authorization does not constitute verification that the patient is covered by a Company health plan. Nor does it guarantee that all hospital expenses will be covered. Eligibility for coverage and the extent to which medical services and supplies will be covered are determined by health plan provisions.

REQUEST FOR PRE ADMISSION REVIEW

PAR SERVICES
A DIVISION OF THE EQUITABLE
P.O. BOX 1247
CORAOPOLIS, PA 15108
TELEPHONE TOLL-FREE
MON.-FRI. 9 AM to 5 PM
800-662-2273
(IN PA 800-342-2399)

AUTHORIZATION NUMBER	
PHONE ☐	MAIL ☐
ORIG ☐ EXT. ☐	ELECTIVE ☐ EMERG. ☐
(OFFICE USE ONLY)	

PRIOR AUTHORIZATION IS REQUIRED FOR ALL HOSPITAL ADMISSIONS

INSTRUCTIONS: Please complete the Employee Section, PART A, and have the PATIENT/GUARDIAN sign the Authorization to Release Information. Have the Attending Physician complete PART B and forward immediately to PAR Services. If you have not received an authorization notice before admission contact PAR Services at the toll-free number above.

PART A — TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME (FIRST) (MI) (LAST)			TELEPHONE NO. (DAY TIME) ( )	SOCIAL SECURITY #
STREET	CITY	STATE	ZIP	EMPLOYER'S NAME
PATIENT NAME (FIRST) (MI) (LAST)	M ☐ F ☐	DATE OF BIRTH MO DAY YR	GROUP NO.	BRANCH # LOCATION

AUTHORIZATION TO RELEASE INFORMATION

I authorize PAR Services or its authorized representatives to view and obtain a copy of all hospital records of the above patient pertaining to the hospitalization described on this form. This information is for the sole use of PAR Services' representative and will not be furnished in an identifiable form to any other person without my written consent unless expressly permitted or required by law. I understand that this authorization may be revoked by written notice to PAR Services, but this will not apply to information already released. If not revoked, this authorization will be valid for a maximum of one year from the date it is signed.

X _____
PATIENT/GUARDIAN SIGNATURE — RELATIONSHIP — DATE

PART B — TO BE COMPLETED BY ATTENDING PHYSICIAN

ADMITTING HOSPITAL NAME			TELEPHONE NO. ( )	ADMITTING DIAGNOSIS	ICD-9 CODE
STREET	CITY	STATE	ZIP	EXPECTED DATE OF ADM.	ANTICIPATED LENGTH OF STAY
PROPOSED SURGERY/PROCEDURE			ICD-9 CODE	DATE OF SURGERY	DAYS AUTH. / DIV. CODE

What other services are anticipated to be performed in the hospital? (Include testing)

MED ☐ SURG ☐	CATEGORY
SSO ☐ PHC ☐	INIT.
(OFFICE USE ONLY)	

List clinical findings, complicating conditions, etc. which affect this hospitalization:

M.D. PLEASE NOTE: If you have not received authorization prior to the admission date, please contact PAR Services. For urgent or emergency admission, please call PAR Services. Authorization will be provided by phone.

PHYSICIAN'S NAME (TYPE OR PRINT)		SPECIALTY		TAX ID NO.
MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO. ( )
PHYSICIAN'S SIGNATURE				DATE COMPLETED

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25

LONG-TERM DISABILITY PLAN

Long-term disability plan

Why a long-term disability plan?

People tend to take their good health — and ability to work — for granted. Everyone assumes that serious illnesses or injuries always happen to someone else. But they don't. What if you were disabled for an extended period of time? Would your savings carry you through? Probably, your answer is no. That's why the Company offers you a Long-Term Disability Plan (LTD). If you participate in this plan, it provides you with a monthly income after you have been totally disabled for six months. It protects you and your family from the financial hardship which could occur when you are unable to work.

Who is eligible?

You are eligible to participate in the plan if you are an active, full-time, salaried employee (i.e., you regularly work at least 30 hours a week).

Enrollment

You may enroll when you join the Company. If you do, your coverage becomes effective after you have been employed for one month. If you enroll within 31 days after the end of your first month, your coverage takes effect on the date you enroll. If you fail to enroll within that time, you must furnish the insurance company with proof of good health before you can be insured. **You may never be allowed to enroll if you are unable to provide satisfactory evidence of good health.**

If you are absent from work because of injury or illness on the day your insurance would otherwise take effect, the effective date will be postponed until the date you return to active work.

$.50 per $100.

Who pays for the plan?

Through payroll deductions, you contribute 50¢ for each $100 of your covered basic monthly earnings.

Coverage is available on annual earnings up to $125,000 — resulting in a maximum contribution of $52.08 a month.

Some Examples

The contribution for an employee who earns $2,000 per month (or $24,000 per year) is calculated like this:

$2,000 ÷ $100 = 20
20 X $.50 = $10.00 monthly contribution

The following table shows contribution rates at various salary levels:

Basic Annual Earnings	Basic Monthly Earnings	Monthly Contribution
$ 10,000	$ 833.33	$ 4.17
$ 15,000	$ 1,250.00	$ 6.25
$ 20,000	$ 1,666.67	$ 8.33
$ 30,000	$ 2,500.00	$12.50
$ 40,000	$ 3,333.33	$16.67
$ 60,000	$ 5,000.00	$25.00
$ 80,000	$ 6,666.67	$33.33
$100,000	$ 8,333.33	$41.67
$125,000*	$10,416.67	$52.08

*This is the maximum level of earnings covered under the plan. Even if you earn more than $125,000, your monthly contribution and your disability benefits will be based on $125,000 annual earnings.

When benefits begin

If you become *totally disabled* as a result of an illness or accident arising on or off the job, you are eligible to receive monthly benefits from the plan. Benefit payments begin on the latest of . . .

- the 181st consecutive day of your total disability, or
- the day after any Company-provided salary continuance benefits stop

. . . provided the insurance company has satisfactory evidence that you are totally disabled.

During the first two years that you receive long-term disability benefits, total disability means that you are unable to perform your regular job. You must be under the regular care of a legally-qualified physician, but house or hospital confinement is not a requirement. After two years of receiving payments, you are considered totally disabled if you are unable to perform any job for which you are reasonably qualified by training, education or experience.

Benefit amount

You will be paid ***60% of your basic monthly earnings.*** The minimum monthly payment is $50 and the maximum is $6,250. Basic monthly earnings refers to your monthly rate of pay at the time your disability began. Earnings don't include bonuses, overtime payments, or any other forms of additional compensation.

If you're a salesperson who earns commissions in addition to your salary, earnings mean your base monthly salary in effect on January 1 of the current year, plus your average monthly commissions for the two prior calendar years. If you've only completed one prior year of service, earnings include your average monthly commissions for that year. If you have less than one prior year of service, earnings include your average monthly commissions for your period of employment. For the calendar year in which you're hired, earnings include only your base monthly salary.

Plan payments will be reduced by the following income benefits to which you may also be entitled:

- primary or family benefits under the Federal Social Security Act or any similar law or act
- any amount payable under Workers' Compensation or Occupational Disease Act or Law. If you receive this amount as a lump sum, it will be treated as if it had been paid in monthly installments.
- any disability income benefits that you receive from any other group insurance plan
- benefits under any Company-provided salary continuance plan
- any pension you receive from a Company pension plan
- benefits payable under any federal or state disability benefits law or act
- benefits payable under no-fault motor vehicle coverage

Benefit amount (continued)

No matter how much income you receive from any of these sources, your monthly benefit from the plan will never be less than $50. Also, any increase in Social Security disability benefits that goes into effect after your disability and Social Security benefits have begun will *not* be used to further reduce your benefits from the plan. In other words, the Social Security increase will be added to your monthly disability income.

Tax Advantage

Because your contributions cover most of the cost of providing LTD coverage, most of any benefit paid from the LTD plan *will not be subject to taxes.* Any benefits which are used as an offset to the LTD benefit (such as Social Security or a Company pension) are generally taxable.

Example

Suppose you are involved in an accident in March. As a result of your injuries, you are unable to perform your job. Your basic monthly earnings before the accident were $2,000. If you were enrolled in the Long-Term Disability Plan at the time of your accident and the insurance company approved your claim, you would be eligible to receive benefits in September (after 181 days of total disability).

Your monthly benefit would be:

$2,000	(basic monthly earnings)
x 60%	
$1,200	(monthly benefit)

If you received disability income from Social Security or other sources, your benefit from the plan would be reduced so that your total monthly benefit from all sources together would total $1,200. For example:

$ 700	disability income from Social Security
+ 500	reduced benefit from LTD plan
$1,200	total monthly benefit

If Social Security benefits later went up to $740, your total monthly benefit would increase to $1,240.

How long you can receive benefits

The length of time you can receive long-term disability payments depends on your age when disability occurs. (See table below.) If at any time you no longer meet the definition of "totally disabled," your payments stop immediately. The insurance company has the right to have you examined periodically to verify that you are still "totally disabled."

Age When Disability Occurs:	Benefits Continue Up To:
61 or younger	first of the month following age 65
62	3-1/2 years
63	3 years
64	2-1/2 years
65	2 years
66	1-3/4 years
67	1-1/2 years
68	1-1/4 years
69	1 year

If your employment with the Company ends, you will continue to receive benefits for any disability that started while you were still covered by the plan.

Minimum Payment Period For Loss Of Hands, Feet Or Eyes

If you have an accident while you are covered by the Long-Term Disability Plan, and you lose a hand, foot or eye within 100 days after the accident, you will receive monthly benefits for at least the number of months shown in this table:

For Loss Of	Minimum Number Of Months
Sight of both eyes	46
Both hands or feet	46
One hand and one foot	46
One hand and sight of one eye	46
One foot and sight of one eye	46
One hand or one foot	23
Sight of one eye	15
Thumb and index finger of either hand	12

If the accident results in more than one of the losses shown in the table, the loss with the highest number of monthly payments will determine the minimum payment

period. Should you die before receiving the minimum number of payments, your beneficiary or estate will receive the balance of the payments.

What the plan does not cover

The plan does not cover disabilities which result from:

- war (declared or undeclared), insurrection, rebellion or participation in a riot
- intentionally self-inflicted injuries

Nor does it cover any period of disability during which you aren't under the care of a legally qualified physician.

When coverage ends

Your long-term disability coverage ends on the earliest of the following dates. The date:

- you're no longer an eligible employee (e.g., you become a part-time employee)
- the group insurance policy expires
- you stop payroll deductions for your coverage
- you reach age 70
- you retire
- your employment terminates

If you are laid off or go on a leave of absence, your coverage stops on your last day of work.

Any disability benefits that you are receiving when your coverage ends will continue.

Other plan facts

Premium Payments During Disability

While you are receiving long-term disability benefits, you do not make any premium payments toward the plan.

Successive Disabilities

Successive periods of disability which result from the same or related cause, and are separated by less than six months of active work are considered one period of disability. You will not have to wait an additional six months before receiving benefits.

Rehabilitation

Following a period of total disability, you may resume active service with the Company by accepting "rehabilitative employment" approved by the insurance company. Rehabilitative employment means any job that:

- your training, education or experience makes you reasonably qualified to perform
- the Company pays you to perform; and
- you perform during a period when you are unable to work at your normal occupation.

Your disability payments — minus 70% of the pay you receive for performing the rehabilitative employment — will continue after you begin rehabilitative employment. However, during this period you will not be paid less than the $50 minimum monthly payment.

No Conversion Privilege

If your coverage ends for any reason, you cannot convert your coverage under this group plan to an individual policy.

How to file a claim

So that your benefits can begin on time, contact your local Personnel or Employee Relations Office after you've been totally disabled for 90 days. They will provide you with a long-term disability claim form which you and your physician must complete. When you return the completed form to the Personnel or Employee Relations Office, they will forward it to the insurance company for approval. The insurance company may ask you to undergo a physical exam; if they do, they will pay the cost. The insurance company must approve your claim before you can receive any benefits.

If your claim isn't paid within 90 days of the date you returned the completed forms (or within 180 days if you were told that there would be a delay), bring it to the attention of the person who handles employee benefits at your location. He or she will discuss it with the local insurance administrator. In most cases, the situation will be resolved reasonably and promptly.

Procedure For Appealing Claims

If your claim is denied, in whole or in part, the insurance company will provide you with a written notice within 90 days from the date they received your claim. The notice will explain the reason(s) for the denial, point out the part of the plan on which the denial is based, and outline the steps you must take to appeal the denial. If you've made an error in your claim, the notice will list ways you can correct it.

You are entitled to appeal a claim that is denied within 60 days of when you received the denial notice. To do so, write to the person who sent you the denial notice. Be sure to state why you believe the claim should not have been denied, and submit any additional information you feel may be relevant. You may review any plan documents that relate to your claim.

You will receive a written decision on your appeal within 60 days of the time the insurance company received your request. Under special circumstances (e.g., to hold a hearing) it may take longer than 60 days to reach a decision. In that case, you'll receive a written notice of the delay within 60 days.

Plan administration

A plan administrator is responsible for providing participants with information about their benefits, processing payments, implementing plan changes and handling any other functions necessary for the plan's operation. The plan administrators of the Long-Term Disability Plan for salaried employees are:

North American Philips Corporation
100 East 42nd Street
New York, N.Y. 10017
(212) 697-3600

and the insurance company. Your Personnel or Employee Relations Office handles plan administration on the local level; they should be your first source for answers to any questions you have about the plan.

Insurance Company

Your Long-Term Disability Plan is insured by the Connecticut General Life Insurance Company, Hartford, Connecticut 06152.

Agent For Legal Process

For all legal procedures, the designated agent for service of process is:

CT Corporation System
277 Park Avenue
New York, N.Y. 10017

Legal process may also be served on the plan administrator.

Plan Year

The plan runs on a fiscal year basis: July 1 through June 30. All employee records which relate to the plan are maintained on the plan year basis.

Employer And Plan Number

The Employer Identification Number (EIN) is 13-1895219 and the plan number is 544.

For More Information

The preceding section summarized the main features of the Long-Term Disability Plan; it is intended to meet the requirement for a summary plan description under the Employee Retirement Income Security Act of 1974 (ERISA).

A full description of your disability coverage appears in the master contract, which governs your rights if it differs from this summary. You may examine this contract at your location within 30 days after the Personnel or Employee Relations Office receives your written request.

Effective Date
This guidebook section summarizes Long-Term Disability Plan benefits in effect as of January 1, 1986.

Your rights under law

As a participant in the Long-Term Disability Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other locations (including worksites), all plan documents including copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. (The 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 annual report.

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

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

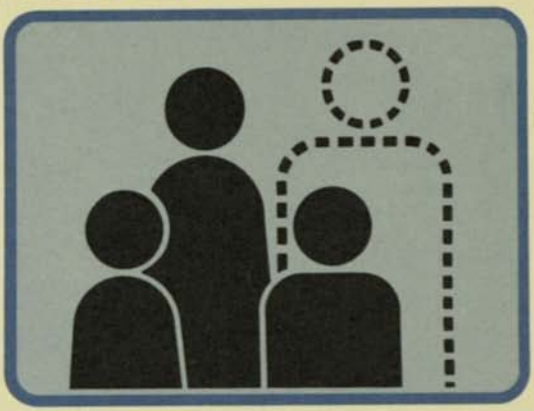
Your rights under law (continued)

it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

The benefits description in this guidebook section does not constitute an express or implied contract of employment.

LIFE PLAN



Group life insurance

Why group life insurance?

When a wage-earner dies, and income stops, the difficulties can be overwhelming. So during your working years, your family needs the kind of financial security that the Company's group life insurance plan provides. As a plan member, you'll automatically have free life insurance. Plus, you can have extra security by purchasing additional coverage at relatively low cost.

Who is eligible?

You are eligible to participate if you are an active, full-time salaried employee (i.e., you regularly work more than 30 hours a week).

Enrollment

Your free life insurance automatically goes into effect after you have been with the Company for one month. You don't have to enroll.

You may enroll for additional coverage when you join the Company. If you do, the additional coverage also becomes effective after you have been with the Company for one month. If you enroll within 31 days after the end of your first month, your coverage begins on the date you enroll. If you fail to enroll within that time, you must furnish satisfactory evidence of good health to the insurance company before you can be insured. You may be asked to undergo a medical examination at your own expense. *You may never be allowed to enroll if you are unable to provide satisfactory evidence of good health.*

If you are absent from work because of injury or illness on the day your insurance would otherwise become effective, the effective date of your coverage will be postponed until the date you return to work.

Amount of insurance

Free Insurance

You are automatically insured for an amount equal to one times your basic annual earnings rounded up to the next higher $1,000 multiple. This amount of free insurance will never be less than $10,000.

1x or 2x

If You Want Additional Coverage

You have an opportunity to purchase additional life insurance at low group rates. Because individual needs differ, the plan offers you two options: you can choose additional coverage of one or two times the amount of your basic annual earnings. In other words, your total coverage can be as high as three times your basic annual earnings.

The kind of insurance you are buying is called "term" insurance. This means your premiums pay for coverage for a specific period of time; you don't build a cash reserve for the future.

Basic Annual Earnings. Basic annual earnings means your annual rate of pay. Bonuses, overtime payments, or any other forms of additional compensation are not included for life insurance purposes.

If you're a salesperson who earns commissions in addition to salary, basic annual earnings means your base salary in effect on January 1 of the current year, plus your average annual commissions for the two prior calendar years. If you've only completed one prior year of service, earnings include your annual commissions for that year. If you have less than one prior year of service, earnings include your annualized average monthly commissions for your period of employment. For the calendar year in which you're hired, basic annual earnings include only your base salary.

Your Contributions For Additional Coverage

The amount you pay each month for additional coverage depends on your age as of January 1 of the current year, as follows:

If Your Age on January 1 of the Current Year Is	Then Your Contribution For Each $1,000 of Additional Coverage Is
Under 40	10¢
40-54	20¢
55-59	50¢
60 or older	65¢

Amount of insurance (continued)

For example, say you are hired in July 1986 at age 40 and you decide to elect additional life insurance. Your birthday was in May. Throughout 1986, you would contribute 10¢ for each thousand dollars of additional coverage since you were only 39 on January 1, 1986. Then on January 1, 1987, you would start contributing 20¢ for each $1,000 of additional coverage.

Some Examples

Assume Jack Smith's age on January 1, 1986 is 39. His basic annual earnings are $30,000. If Jack decides to elect additional life insurance of one times his basic annual earnings, his monthly contribution is figured like this:

Contribution Rate Based On Age	X	Thousands Of Additional Coverage	=	Monthly Cost
10¢	X	30		$3.00

His total life insurance is $60,000 ($30,000 free plus $30,000 additional). The following year, when Jack's age as of January 1 will be 40, his contribution rate goes up to 20¢ per $1,000 of additional coverage — making his monthly cost $6.00.

June Harris is age 57 and has basic annual earnings of $42,000. If she elects additional coverage of two times basic annual earnings, her contribution is figured like this:

Contribution Rate Based On Age	X	Thousands Of Additional Coverage	=	Monthly Cost
50¢	X	84		$42.00

For $42.00 a month, June has total life insurance coverage of $126,000 ($42,000 free plus $84,000 additional).

Maximum Coverage

The maximum amount of life insurance coverage for any individual is $1,000,000.

$1000 multiples

Rounding Out Your Benefit Level

If your basic annual earnings are not an even $1,000 multiple, your insurance will be rounded up to the next higher $1,000 multiple — as shown in these examples:

Suppose your basic annual earnings are $10,200. This amount would be rounded up to $11,000 in computing your free insurance. If you opt for additional coverage equal to one times earnings, your additional coverage would be $11,000. Add this to your free $11,000 benefit and your total coverage is $22,000.

If you choose additional coverage equal to two times earnings, your $10,200 is doubled to $20,400 and then rounded up to $21,000 of insurance. With your free $11,000 benefit, your total coverage is $32,000.

Changing Your Additional Coverage

You can change the option you chose during your initial enrollment at any time afterward. If you elect additional coverage equal to two times basic annual earnings, you can decrease this amount to one times basic annual earnings. You may also *increase* your additional coverage from one to two times basic annual earnings; *however, you must first submit satisfactory evidence of good health to the insurance company.*

When Your Salary Changes

When you receive a salary increase, and you become eligible for a higher amount of life insurance, the new amount automatically goes into effect on the day your salary increases. If you are absent from work because of injury or illness on the day your insurance is scheduled to change, the new amount will become effective on the day you return to work.

Should your salary decrease, your amount of life insurance will remain the same (unless you're a commissioned salesperson whose earnings are calculated each January 1).

If You Work Past Age 65

If you work past age 65, you may continue to participate in the life insurance plan. However, starting with your 65th birthday the benefit payable upon your death is reduced by 8% a year, as follows:

If You Die On Or After Your	Your Beneficiary Receives This % Of Your Full Insurance Amount
65th birthday	92%
66th birthday	84.64%
67th birthday	77.87%
68th birthday	71.64%
69th birthday	65.91%

Note, though, that the amount you contribute for any additional coverage is based on your *full* insurance amount.

For example, say you are age 67 and your basic annual earnings are $25,000. You have elected additional life insurance of two times your basic annual earnings ($50,000). Your full insurance amount, then, is $75,000 ($25,000 free plus $50,000 additional).

Amount of insurance (continued)

Your monthly contribution for additional coverage is $32.50 (65¢ per thousand of additional coverage). If you die in active service at age 67, your beneficiary receives $58,402.50 (77.87% of $75,000).

On your 70th birthday, your participation in the life insurance plan ends.

Payment of life insurance

Your Beneficiary

You can select anyone as the beneficiary of your group life insurance. You can name more than one person and you have the right to change your beneficiary at any time. You should contact your Personnel or Employee Relations Office for the appropriate forms.

If you have no designated beneficiary when you die, benefits will be paid to your survivors in the following order of priority: your spouse, children, parents, brothers and sisters, executors or administrators. If your beneficiary is a minor who doesn't have a legal guardian, the benefit may be paid at a rate not exceeding $50 per month to the adult who the insurance company determines has assumed custody of the minor.

How Your Life Insurance Is Paid

Your insurance is paid to your beneficiary should you die from any cause while you are insured. Ordinarily, this benefit is paid in one lump sum, but your beneficiary can make arrangements for monthly installments.

How To File A Claim

The Personnel or Employee Relations Office at your location will assist your beneficiary in filing the appropriate claim form with the insurance company.

Procedure For Appealing Claims

If your beneficiary's claim for your insurance is denied, in whole or in part, the insurance company will provide a written notice within 90 days from the date they received the claim (or 180 days if they notified the beneficiary that there would be a delay). The notice will explain the reason(s) for the denial, point out the part of the plan on which the denial is based, and outline the steps your beneficiary must take to appeal the denial. If your beneficiary has made an error in the claim, the notice will list ways it can be corrected.

Your beneficiary is entitled to appeal a claim that is denied within 60 days of when he or she received the denial notice. He or she may also review any plan documents that relate to the claim. To appeal, your beneficiary should write to the person who sent the denial notice. The appeal should state why the beneficiary believes the claim should not have been denied and should include any additional information that may be relevant.

Your beneficiary will receive a written decision on the appeal within 60 days of the time the insurance company received the request. Under special circumstances (e.g., to hold a hearing), your beneficiary will receive a decision within 120 days of the appeal.

Other important facts

Income Tax On Life Insurance

If your total life insurance coverage exceeds $50,000, a portion of your insurance may count as income for income tax purposes. The taxable amount (if any) is determined by an IRS formula based on your age and the premiums you pay. Any taxable amount will be included in your income on your W-2 form.

When Coverage Ends

Your group life insurance terminates on the earliest of the following dates:

- your 70th birthday
- the date the group policy terminates
- the date you are no longer eligible
- your last day of active service with the Company, or the end of the period for which the last payroll deduction was made, whichever date is later
- the date you retire

Coverage will continue during temporary layoffs or leaves of absence, up to the end of the third month following the month that you left active service — provided that you pay the premium for coverage. In no event will coverage extend beyond the third month after your layoff or leave of absence began.

If You Become Disabled

Your coverage will continue up to age 70 as long as you remain disabled. There is no cost to you unless you're receiving full pay from a Company-provided salary continuance program. Your insurance amount will be reduced by 8% for each year starting with your 65th birthday. If you retire while disabled, your life insurance coverage will terminate on the date of your retirement.

Conversion Privilege

You can convert your group life insurance to a permanent individual policy, without a medical examination, if you apply within 31 days after the date your group life insurance terminates because you've left the Company or transferred to an employment status not covered by this plan. Special conditions apply to conversion if the group policy is terminated. Contact your local Personnel or Employee Relations Office for conversion information.

The rates for an individual life insurance policy are based on your age at the time you convert your group life insurance, and the amount of insurance you convert.

If you die within the 31-day period allowed for conversion, your beneficiary will receive payments under the *group* policy. And any premiums you may have paid toward an individual policy will be refunded. If your individual policy beneficiary is someone other than the beneficiary you'd named under the group policy, the benefits payable from the group policy will be paid to the beneficiary you named for the individual policy.

The insurance company may refuse to issue a converted policy if doing so would result in overinsurance or duplication of coverage.

DEPENDENT LIFE INSURANCE

Enrollment

When you join the Company, you'll receive an enrollment form for dependent life insurance which you must complete and return to the Personnel or Employee Relations Office. If you indicate that you want to participate, this form authorizes the Company to deduct the required plan contributions from your paycheck.

If you enroll when you first join the Company, your dependents' life insurance will go into effect after you have been employed for one month. If you enroll your dependents within 31 days after the end of your first month, their coverage begins on the date you enroll them. If you enroll your dependents any later than that, you must furnish the insurance company with satisfactory evidence of your dependents' good health before they can be insured. They may be asked to undergo a medical examination at your expense. Should your dependents be unable to furnish satisfactory evidence, you will not be able to get dependent life insurance coverage.

If you are absent from work because of injury or illness on the day your dependents' life insurance would otherwise take effect, the effective date of coverage will be postponed until the date you return to work.

Amount of insurance

You may insure your "dependents," — that is, your spouse (unless legally separated or divorced) and eligible children. Your spouse can be insured for $5,000 and each eligible child for $1,000.

Children

- **Children** — Children eligible for dependent life insurance include unmarried children from 14 days of age to their 19th birthday. They can be . . .
  - — your own children,
  - — stepchildren,
  - — adopted children, or

Amount of insurance (continued)

— any children permanently residing in your household in a parent-child relationship

. . . provided that they are primarily dependent upon you for support.

- **Students** — Coverage will be continued until age 25 for your unmarried children while they are attending school as full-time students and are primarily dependent upon you for support.

Cost

Your cost for dependent life insurance coverage is $1.25 per month, no matter how many dependents you have.

Payment of insurance

Upon the death of an insured dependent, you receive the full benefit in one lump sum.

These special payment rules apply if you are not alive when dependent life insurance becomes payable:

- if your spouse dies — payment goes to your spouse's executors or administrators
- if a child dies — payment goes to the first surviving class of the following beneficiaries (1) surviving parent (2) surviving brothers and sisters (3) executors or administrators. (Should a beneficiary be a minor with no legal guardian, the benefit may be paid at a rate not exceeding $50 a month to the adult who the insurance company determines has assumed custody and principal support.)

How to file a claim

Notify the Company immediately of the death of a covered dependent. The Personnel or Employee Relations Office will assist you in filing the appropriate claim form with the insurance company.

The procedure for appealing claims, explained on page 5, also applies to any dependent life insurance claim.

When coverage ends

Your dependent life insurance terminates on the earliest of the following dates:

- when you reach age 70
- the date the group policy terminates
- the date you are no longer eligible

- the last day of active service with the Company or the end of the period for which the last payroll deduction was made, whichever is later
- the day your dependent is no longer eligible
- when you retire
- the end of the third month following the month you become totally disabled.

Coverage will continue during temporary layoffs or leaves of absence, up to the end of the third month following the month that you left active service — provided that you pay the premium for coverage. In no event will coverage extend beyond the third month after your layoff or leave of absence began.

Conversion privilege

You can convert your dependent's life insurance to a permanent individual policy, without a medical examination, if you apply within 31 days after the date your dependent's life insurance terminates because you or your dependent are no longer eligible, or you stop contributing to the plan. Special conditions apply to conversion if the policy is terminated. See your local Personnel or Employee Relations Office for conversion information.

The rates for an individual life insurance policy are based on your dependent's age at the time you convert the insurance, and the amount of insurance you convert.

If your dependent dies within the 31-day conversion period, you will receive the amount payable under the group policy (even if you had requested conversion to an individual policy). Any premiums you may have paid under the individual policy will be returned to you.

The insurance company may refuse to issue a converted policy if doing so would result in overinsurance or duplication of coverage.

Plan administration

Plan Administrator

A plan administrator is responsible for providing participants with information about their benefits, processing payments, implementing plan changes and handling any other functions necessary for the plan's operation. The plan administrator of the group life insurance plan for salaried employees is:

North American Philips Corporation
100 East 42nd Street
New York, N.Y. 10017
(212) 697-3600

Your Personnel or Employee Relations Office handles plan administration on the local level; they should be your first source for answers to any questions you have about the plan.

Insurance Company

Your benefits are insured by The Equitable Life Assurance Society of the United States, 1285 Avenue of the Americas, New York, N.Y. 10019.

Agent For Legal Process

For all legal procedures, the designated agent for service of process is:

CT Corporation System
277 Park Avenue
New York, N.Y. 10017

Legal process may also be served on the plan administrator.

Plan Year

Records for the plan are kept on a calendar year basis ending each December 31.

Employer And Plan Number

The Employer Identification Number (EIN) is 13-1895219 and the plan number is 501.

Effective Date

This guidebook section summarizes life insurance benefits in effect as of January 1, 1986.

Your rights under law

As a participant in the group life insurance plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other locations (including worksites), all plan documents including copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. (The 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 annual report.

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

The benefits description in this guidebook section does not constitute an express or implied contract of employment.

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The Equitable Life Assurance Society of the United States

NEW YORK, NEW YORK

CERTIFICATE OF INSURANCE

This is to certify that, subject to the terms of Group Policy(ies) combined for dividends with Group Policy #63601,D,H,M,DE, the salaried employees of the Policyholder named below, are insured for the benefits described in Benefits, below.

NORTH AMERICAN PHILIPS CORPORATION

BENEFITS

The Equitable benefits for which you are insured are set forth in the plan booklet. Insurance takes effect only if you are eligible for it, you elect it and you make contribution for it, as required.

This certificate takes the place of any prior one issued to you covering this insurance. It is not the insurance contract; each policy and the Policyholder's application for it are the contract. This certificate is evidence of insurance under the policy(ies). This insurance takes effect only for persons who become and stay insured under each such policy.

Your Group Life insurance may be assigned under certain conditions. If you wish to make an assignment of your Group Life insurance, see your Employer for the conditions and further information.

EMPLOYEE LIFE INSURANCE

When the Equitable receives due proof of your death, the amount for which your life is insured by the Group Policy will be payable to the beneficiary named by you, as shown on the records kept on the policy. Any part of your insurance for loss of life for which there is no named beneficiary will be payable in accordance with the terms of the policy.

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

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PF26003(1.2)(2.5)

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Protection after Termination

A. If your Group Life insurance ends because your employ ends in the class(es) insured by the policy, you may, within thirty-one days after your insurance ends, apply to convert to an Individual Life insurance policy. However, it cannot be a policy providing: (i) term insurance; or (ii) benefits for disability; or (iii) extra benefits for accidental death.

You will have the same rights and benefits with respect to any part of your insurance ended due to age as though such part of your insurance ceased because your employ ended.

For it, you will not need a health exam. The converted policy will take effect thirty-one days after your Group insurance ends; but you must have paid the first premium on or before such date. You may choose to convert to a sum equal to or less than the sum which ceased under the Group Policy. If your employ in a class insured by the policy ends, but you are still in the Policyholder's employ, the sum you may convert will be reduced by the sum for which you are eligible under any other group policy in the thirty-one days in which you may convert.

If you die within thirty-one days after your insurance ends as described in this part A., the Equitable will pay to your beneficiary the sum of the Group Life Insurance you could have converted.

B. If your Group Life insurance ends because the Group Policy, or the insurance on the class of which you are a member, ceases, you may apply to convert to an Individual Life insurance policy. You may convert in the same way as described in part A; but to do so you must have been insured by the Group Policy for at least five years in a row.

The sum you may convert will be reduced by any sum for which you are eligible under any other group policy in the thirty-one days in which you may convert. In no case may the sum you convert under this part B. be more than $2,000.

If you die within thirty-one days after your insurance ends as described in this part B., the Equitable will pay a sum to your beneficiary if you had been insured under the Group Policy for at least five years in a row. This sum will be the amount of Group Life insurance for which you were last insured under the Group Policy less any sum for which you became insured under any other group policy within thirty-one days after the date your Group Life insurance ended. In no case will the amount payable be more than $2,000.

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DEPENDENT LIFE INSURANCE

On receipt of due proof of a dependent's death, the amount of insurance for which his or her life is insured under the Group Policy will be payable to you. If you are not living at the death of such dependent, such amount will be payable in accord with the terms of the policy.

Protection after Termination

A. 1. If your dependent's Group Life insurance ends due to your death or your retirement, or because your Group Life insurance ends due to your employ ending in the class(es) insured by the policy, he or she may within thirty-one days after his or her insurance ends, apply to convert to an Individual Life insurance policy. However, it cannot be a policy providing: (i) term insurance; or (ii) benefits for disability; or (iii) extra benefits for accidental death.

Your dependent does not need a health exam. The converted policy will take effect thirty-one days after his or her Group Life insurance ends; but he or she must pay the first premium on or before such date.

Your dependent may choose to convert to a sum equal to or less than the sum which ceased under the Group Policy.

2. If your dependent's Group Life insurance ends because the Group Policy ceases or is amended, he or she may apply to convert to an Individual Life insurance policy in the same way as described in part A.1. However, he or she must have been insured by the Group Policy for at least five years in a row. The sum such person could convert, as set forth in part A.1., will be reduced by any sum he or she is eligible for under any other group policy within thirty-one days after this Group Life insurance ends. In no case can the sum such person may convert under this part A.2. be more than $2,000.

PF26003 Amended by PF 26517(N)

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Protection after Termination (Continued)

B. 1. If your dependent's Group Life insurance ends: (a) because your employ ends in the class(es) insured by the policy or because you retire, and such person dies within thirty-one days after such event; or (b) because of your death and such person dies within 6 months after your death, the Equitable will pay the sum for which he or she was last insured under the Group Policy.

2. If your dependent dies within thirty-one days after his or her insurance ends as described in part A.2., the Equitable will pay the sum of Group Life insurance for which such person was last insured. He or she must have been insured under the Group Policy for at least five years in a row. This sum will be reduced by any sum for which such person became insured under any other group policy within thirty-one days after the date his or her insurance ended. In no case will the amount payable be more than $2,000.

No payment shall be made under part B., if (i) at the death of the dependent he or she is eligible for insurance under the Group Life policy as an employee; or (ii) at the date of a child's death, he or she is married or has reached the age limit.

17/life