BEFORE THE COURT-APPOINTED REFEREE
IN RE LIQUIDATION OF THE HOME INSURANCE COMPANY
DISPUTED CLAIMS DOCKET

In Re Liquidator Number:	**2005-HICIL-9**
Proof of Claim Number:	**EMPL17943**
Claimant Name:	**JOHN J. DEMKO**

THE LIQUIDATOR'S SUPPLEMENTAL MEMORANDUM

Roger A. Sevigny, Insurance Commissioner of the State of New Hampshire, acting solely in his capacity as Liquidator of The Home Insurance Company (the "Liquidator"), by and through counsel, hereby submits this supplemental memorandum in accordance with the ruling of Referee Paula T. Rogers rendered on January 27, 2006 affirming "the Liquidator's Class V designation of the claim," and acknowledging Claimant John J. Demko's ("Claimant") desire to fully resolve his claim thereby affording the parties the opportunity to submit additional information pertinent to the issue of value determination.

PRELIMINARY STATEMENT

On June 1, 2004, Claimant filed a Proof of Claim in the Home estate. Claimant sought $216,148.00 comprised of $85,710.00 as his "[T]otal Health Insurance Additional Cost Claim" and $130,438.00 for his "Pension Benefits Claim." *(Case file tab 4, ¶5 attachments).* The gravamen of Mr. Demko's claim is that "The Home Insurance Company senior management and board of directors destabilized an old-line company through their mismanagement and greed" and that ". . . disabled employees should share in whatever distribution is made . . . ." *(Case file tab 4, ¶5 attachments).*

The Liquidator, by Sally Goldberg, Home Vice President, Human Resources, issued a Notice of Determination disallowing, in full, Claimant's Proof of Claim on August 4, 2005. Specifically, the Notice of Determination stated:

> "The Company's Summary Plan Description dated 1/88 and in effect at the time of your employment hire date states the "the Home expects and intends to continue the Medical Plan indefinitely, but reserves the right to amend or end it if this is considered necessary or desirable." *(Exhibit 1, p.16).* As an employee on inactive status, you would have been sent REM Benefits Bulletins post-1995 that described the benefits and associated changes for each plan year. In these bulletins you were notified that "the company reserves the right and discretion to amend, modify, change or terminated [sic] each benefit plan cited herein for any reason or at any time with respect to actively employed, inactive or former employees, their dependents and beneficiaries."
>
> While you were previously eligible for the employer-paid portion of medical benefits coverage, as a result of the insolvency of The Home, we are not able to continue to pay for this coverage. You were sent a notice in this regard in August 2003 *(Case file tab 4 attachments)* with a follow up clarifying note in September 2005 [sic] *(actually sent 9/18/2003 attached as Exhibit 2).*
>
> In addition, your claim for pension plan credit beyond 12/31/1995 does not present a valid claim against the Home estate. All employees – active and inactive – were impacted by the decision to have the Home pension plan frozen effective 12/31/95. This meant that neither earnings nor employment service after 12/31/95 was to be counted for purposes of determining the amount of benefit under the Home Retirement Plan. You were sent a letter dated June 18, 1997 addressing your retirement calculation worksheet dated April 3, 1997 indicating you were vested in the Home Retirement Plan with your projected annual retirement benefit." *(Case file tab1).*

Claimant rejected the Determination and filed an Objection dated September 12, 2005. *(Case file tabs 2,3).* The Liquidator respectfully requests that the Referee confirm that he properly determined that Claimant's claim in the Home estate has a "zero" value.

ARGUMENT

ERISA Is The Governing Law For Claimant's Dispute

Employee benefit plans are governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and ERISA preempts any state law claims. *Hotz v. Blue Cross & Blue Shield of Mass.*, 292 F.3d 57 (1st Cir. 2002).

ERISA divides employee benefit plans into two categories -- welfare benefit plans and pension plans. 29 U.S.C. §1002 (Section 3 of ERISA). It is clear from the language of ERISA and the cases interpreting it that medical insurance plans are welfare benefit plans. *UAW Local No 1697 v. Skinner Engine Co.*, 188 F.3d 130 (3rd Cir. 1999) (court treated retiree life and health plans as welfare plans.) Accordingly, Claimant's dispute regarding his health benefits is appropriately classified as a welfare benefit plan dispute within the parameters of ERISA.

Employee Welfare Plans Can Be Terminated At Will By The Employer

ERISA expressly exempts employee welfare benefit plans from the vesting requirements, which grant plan participants a statutory right to continued benefits. 29 U.S.C. §1051(1) (ERISA Section 201(1)). (This Section exempts employee welfare plans from Part 2 of ERISA, which includes the vesting rules.) Consequently, "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corporation v Schoonejongen,* 514 U.S. 73, 78, 115 S. Ct. 1223, 1228 (1994). Hence, Home was well within its rights to terminate the medical plan benefit of which Claimant was a recipient.

Home Did Not Waive Its Right
To Terminate The Instant Plan

Even though an employer can contractually obligate itself to provide vested benefits under a welfare plan, thereby waiving its statutory right to terminate the plan, the courts will recognize a contractual right to vested benefits, only if such right is expressly granted by the plan documents. *Gable v. Sweetheart Cup Co., Inc.,* 35 F.3d 851, 855 (4th Cir.), *cert. denied*, 514 U.S. 1057 (1995); *Wise v. El Paso Natural Gas Co.,* 986 F.2d 929, 935 (5th Cir. 1993).

There is no requirement that the employer specifically reserve its right to terminate a plan. "Given our presumption against the vesting of welfare benefits, silence indicates that welfare benefits are not vested." *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 632 (7th Cir. 2004). Where the Summary Plan Documents go beyond silence and specifically reserve the right to terminate a plan, it is extremely difficult for a plaintiff to overcome the presumption against vesting. See *Gable*, 35 F.3d at 856 ("This express reservation of the company's right to modify or terminate the participant's benefits is plainly inconsistent with an alleged intent to vest those benefits."); *Jensen v. SIPCO, Inc.,* 38 F.3d 945, 950 (8th Cir. 1994), *cert. denied*, 514 U.S. 1050 (1995) ("We agree that a reservation-of-rights provision is inconsistent with, and in most cases would defeat, a claim of vested benefits.") In the present case, not only did Home not waive its right to terminate the instant plan, it specifically reinforced its right to terminate same in communications to all affected employees, including Claimant. *(Case File Tab 5, See e.g., Exhibits 1,3,4,5).*

Although Not Required By Law, Home Clearly And Unequivocally Reserved Its Right To Amend, End, Or Otherwise Alter Its Medical Insurance, And Other, Welfare Benefits

Assuming arguendo, that Home was under an obligation to reserve its right to change medical insurance or other welfare benefits it afforded its employees, it clearly met, or surpassed,

that obligation by virtue of the clear reservation language present in the Summary Plan Descriptions of its various welfare benefit programs, including the Summary Plan Description dated 1/88 which was in effect at the time Claimant accepted employment with Home. As noted above, the Summary Plan Description plainly states that Home ". . . reserves the right to amend or end it [the Medical Plan] if this is considered necessary or desirable." *(Exhibit 2, p.16).* Further, the December 2, 1996 Benefits Letter sent to all "Home Insurance Company Long Term Disabled Employees" by Home's then third party benefits administrator, Risk Enterprise Management Limited (REM), clearly stated, "[T]he Company reserves the right and discretion to amend, notify, change or terminate each benefit plan cited herein for any reason or at any time with respect to actively employed or former employees, their dependents and beneficiaries." *(Case file tab 5, Exhibit 3).* Subsequent correspondence from REM, dated September 16, 2002, placed Claimant on notice that even though the medical insurance benefit was still effective as of that date, the benefit would "be terminated in the event and at the time The Home Insurance Company ceases to reimburse REM for the cost of this benefit." *(Case file tab 5, Exhibit 4).* Similarly, by memo dated November 11, 2002 addressed to "Home Insurance Company Inactive Employees in Disabled Status. . ." the company again reserved "the right and discretion to amend, modify, change or terminate each benefit plan cited. . . ." *(Case file tab 5, Exhibit 5).*

Thereafter, by memo dated August 29, 2003, Home's Special Deputy Liquidator advised all "Individuals Receiving Home Disability-Related Benefits" that Home was "unable to continue to pay its portion of welfare benefits (medical, dental, life) for individuals with disability-related benefits" and that "Home-funded disability-related welfare benefits. . . [would] terminate effective September 30, 2003." *(Case file tab 4).* Memo recipients, such as Claimant, were afforded the opportunity to convert their medical insurance coverage to an individual policy and instructions pertaining to same were included within the memo. *(Case file tab 4).*

Having gone to great lengths to afford employees with ample notice of the potential to amend or end welfare benefits, Home clearly acted appropriately in terminating the medical insurance coverage that Claimant had been a recipient of.

Claimant Received No Disparate Treatment When Home Rightfully "Froze" Its Retirement Plan Effective 12/31/1995

Claimant has also posited that "[F]reezing the [Home Retirement] plan clearly discriminates against disabled employees." *(Case file tab 2).* Quite the contrary, all employees of Home as of December 31, 1995, regardless of their official status as active or inactive employees, were treated identically regarding earnings and time of service calculation. Furthermore, in response to Claimant's oblique reference to purported ERISA violations, *(Case file tab 2),* both ERISA and the cases that have interpreted it fully support an employer's right to "freeze" its pension plan. See *Corcoran v. Bell Atlantic Corp.,* 1997 U.S. Dist. LEXIS 14662 (E.D. Pa. 1997); ("Instead of amending the pension plan . . .Bell Atlantic could lawfully have "frozen" the plan by completely eliminating any future accrual. . ."); See also *Melvin v. U.A, Local 13 Pension Plan,* 131 Fed. Appx. 737; 2005 U.S. App. LEXIS 3118 (2d Circ. 2005).

Finally, Claimant contends that he has been damaged by Home's "senior management greed and mismanagement." *(Case file tab 2).* Again, the Liquidator's "zero" determination is appropriate given that Claimant's "proof" of malfeasance by Home senior management personnel amounts to nothing more than unsubstantiated accusations. Claimant presents no specific acts, errors or omissions. Nor does Claimant provide any evidence of a causal relationship between any claimed acts and the "financial loss" at issue. As such, the Liquidator properly rendered his determination.

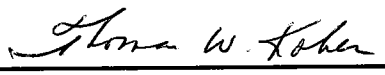
CONCLUSION

For the reasons set forth herein, the Liquidator respectfully requests that the Referee: (1) dismiss Claimant's Objection to the Liquidator's Notice of Determination; (2) rule on the bifurcated issue of value that the Liquidator's recommended Determination, as set forth in the Notice of Determination, assigning a "zero" value to Claimant's claim be allowed as stated; and (3) grant such other and further relief as is deemed appropriate in the circumstances.

Respectfully submitted,

ROGER A. SEVIGNY, INSURANCE COMMISIONER of the STATE OF NEW HAMPSHIRE, as LIQUIDATOR OF THE HOME INSURANCE COMPANY,

By his attorneys,



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February 3, 2006

CERTIFICATE OF SERVICE

I hereby certify that copies of this Supplemental Memorandum have been forwarded this 3rd day of February 2006 via First Class mail to Claimant and by e-mail to counsel identified below.

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Medical Plan

Highlights of this booklet

A Most Valuable Plan

The Medical Plan provides sound and comprehensive assistance when you're faced with the prospect of illness or injury. With today's soaring medical costs, it could be the most valuable benefit you have. This chart gives the highlights of the Medical Plan.

In addition to the coverages listed below, the STOP LOSS PROVISION limits your out-of-pocket expenses to $1,600 for individuals, and $1,800 for families per calendar year including the deductible.

You and each of your enrolled dependents have a MAXIMUM LIFETIME benefit of $500,000.

Highlights of the Medical Plan

No deductible	After deductible ($200 Per Person, $400 per family)	
100% coverage	**80% coverage**	**50% coverage**
■ second opinion on certain elective surgeries	■ hospital benefits, including semiprivate room, tests and supplies	■ certain elective procedures for which a second confirming opinion is not sought *or,* a confirming second or third opinion is not received
■ the first $200 of covered expenses incurred due to an accident	■ home health care provided by approved agencies	■ outpatient doctors' services and prescription drugs for mental illness or functional nervous disorders (benefits limited to $25 per visit to a maximum of $1,000 a year, i.e. $50 maximum allowable charge per visit x 50% = $25 maximum benefit)
■ outpatient surgery	■ surgical-medical benefits, including fees for surgeons, assistant surgeons, and specialists; physical therapy; x-rays; and radiation treatment	
■ outpatient testing before a non-emergency hospital admission	■ certain elective surgical procedures *after* a confirming second opinion	
	■ emergency care	
	■ prescription drugs	
	■ maternity benefits	
	■ treatment of alcoholism and drug addiction at a legally constituted hospital	

Costs

The cost of the Medical Plan is shared by participating Companies and enrolled employees. Rates are based on Plan "experience" — that is the amount of benefits paid out over the preceding year. While the exact proportion of the total rate paid by your employer may vary from year to year, it's generally around 80%. Employee pre-tax contributions make up the balance. These pre-tax contributions are made before federal (and most state and local) income and Social Security taxes are withheld from your pay. You'll be told your exact cost, of course, when you sign up for coverage.

Alternative Medical Coverage—HMOs

Health Maintenance Organizations (HMOs) provide individual or family health care through their own staff or affiliated physicians and specialists at affiliated hospitals and facilities. You can join an HMO as an alternative to the Medical Plan if your employer offers one where you reside. If you do not enroll at the time of hire, and then want to enroll later, you and your eligible dependents will be required to prove good health in the last quarter of the calendar year. If approved, enrollment in the regular Medical Plan will be effective January 1. You will then be eligible to enroll in the HMO during the next open enrollment period. Open Enrollment is usually the last two weeks of January with an effective date of March 1.

Each HMO provides its own medical benefits and follows its own claim procedures. For more information on whether HMOs are offered in your area, and the benefits and claim procedures which apply, you or your eligible dependents may contact your local personnel representative or the Employee Benefits Department, Group Insurance Section-New York Office. If you enrolled in a participating HMO contact your HMO directly for any additional information and answers to your questions.

When to Enroll

All full-time employees can join the Plan as soon as they're hired. In order to enroll as a "new employee," just fill out the enrollment form you'll receive at that time. You can get Individual Coverage for yourself — or you can get Family Coverage and include your eligible dependents. You have until the first day of the month following your first day of work to enroll in the plan.

Once you've joined, please notify your supervisor if there's any change in your family status. You must enroll for changes in coverage within 31 days of a *Life Event*.

A Life Event is:

- *marriage or divorce*
- *death of spouse or child*
- *birth or adoption of a child*
- *change in a spouse's or child's employment status*
- *a spouse or child becomes ineligible for coverage.*

Other than a Life Event you may only change your coverage before the beginning of each calendar year. The change will be effective January 1. You and your eligible dependents will be required to prove good health if you did not elect coverage when first eligible or at the time of a Life Event.

When Coverage Starts

Coverage for you and your enrolled dependents begins on the first day of the *month after* you become an employee. If you're not working full-time on that day, coverage begins when you return to full-time work.

You may make a written election to begin your coverage immediately, as of your date of hire. If you elect immediate coverage, you must pay the entire cost (without employer subsidy) during the normal waiting period. This cost will be deducted on a pre-tax basis through payroll deductions.

If an enrolled dependent, other than a newborn child, is in the hospital or confined at home under medical care on the date he or she would be eligible for medical coverage that coverage won't start until he or she is in good health again.

How We Define Eligible Dependents

Eligible dependents include your spouse and your unmarried, dependent children less than 19 years old. Unmarried children older than 19 will continue to be eligible for coverage until the end of the calendar year in which they reach 23, provided they're wholly dependent on you for support.

Stepchildren, foster children and legally adopted children are eligible under the Plan also, provided they're dependent on you for support. Coverage can be continued for those unmarried children reaching age 23 who are incapable of self-support due to some mental or physical handicap. The coverage can stay in effect as long as the condition lasts and the child remains single. In such cases, the Employee Benefits Department, Group Insurance Section-New York Office would have to be notified within 31 days after coverage would otherwise end (i.e., the end of the year during which the child becomes 23). Additional proof of continued disability will be required from time to time.

If you're enrolled as an employee in this Plan you can't be considered the eligible dependent of a relative who is also enrolled as an employee. Eligible dependents status does not continue while serving in the armed forces.

In Case of Late Enrollment

If you don't join the Plan when you're first employed, or *if you don't change your coverage within 31 days of a Life Event*, you and/or your dependents will be required to prove good health before coverage can be effective. It's possible coverage might be denied under some circumstances. You must notify the Employee Benefits Department and complete the necessary forms to provide evidence of good health. These forms must be completed and processed prior to year end. It normally takes 2 months for processing. If approved, coverage will be effective the next January 1.

Your Benefits in More Detail

The Medical Plan provides benefits for a wide range of services for care both in and out of the hospital. The following three sections show what expenses are 100%, 80% and 50%

covered. The last section lists services not covered.

Expenses 100% Covered

Second Surgical Opinion

Metropolitan will provide the names of Board Certified Specialists in your area who can provide a second opinion for certain elective surgeries. You'd select a doctor from that list, and charges for a second or third opinion (if the first two doctors disagree) would be 100% covered under the Plan with no requirement that the deductible be met. This applies only to those elective procedures (see page 5) where a confirming second opinion is mandatory in order to receive 80% coverage. For other second opinions, the Plan pays 80% after the deductible has been met.

Call toll free 1-800-451-4720 for the names of second opinion physicians.

The First $200 of Accident Costs

Our Accident Provision will cover the first $200 of covered medical expenses for each accident at 100% exclusive of the deductible.

Outpatient Surgery

Surgeries performed on an outpatient basis will be 100% covered with no deductible. (The same surgery performed on an inpatient basis would be covered at 80% after meeting the deductible.) This includes charges by hospital, ambulatory surgical center, surgeon and anesthesiologist.

Some of these surgical procedures are listed in this Booklet under "Elective Procedures" (page 5). A second confirming opinion or a third opinion (if the first two doctors disagree) is required, to receive the 100% reimbursement for these outpatient surgical procedures.

You can choose to have the surgery performed on an outpatient basis at a hospital or an approved state-licensed ambulatory surgical center. Be sure to check with your local personnel representative for more information before you select a surgical center.

Outpatient surgery performed because of an accident will be paid at 80% after the Accident Provision and deductible have been applied. (See page 10, example 2.)

Outpatient Testing

Outpatient testing performed up to approximately ten days prior to a non-emergency hospital admission will be 100% covered and not subject to the deductible. These tests may be performed at your doctor's office, a laboratory or a hospital. (In-hospital testing will be covered at 80% after the deductible has been met.)

Expenses 80% Covered

Hospital Benefits

When you or one of your enrolled dependents is admitted to a hospital the Plan pays:

- 80% of the cost of a semi-private room or intensive care unit
- 80% of *hospital costs* for these tests and supplies:

general anesthesia supplies and equipment charges

basal metabolic examinations

blood transfusion equipment charges and related expenses

cardiographic and physiotherapeutic equipment charges

cystoscopic examination and equipment charges

dressings and plaster casts

diagnostic laboratory and x-ray examinations

operating and recovery room charges and related equipment charges

radiation therapy for inpatients — including most radium, radioactive isotope and x-ray treatments

Home Health Care

The Plan will cover 80% of the reasonable and customary cost for approved services and treatment provided by home health care agencies. In order to qualify for coverage, a home health care plan must be prescribed by your doctor and administered by an approved agency. The benefits include:

- up to 100 home visits a year provided by a home health care agency or by a visiting nurse service in an area where an agency isn't available (up to 4 hours constitute one home visit);
- part-time services of a health aide under the supervision of a Registered Nurse and services of a physical, speech or occupational therapist if required as part of a home health care plan;
- medical supplies or laboratory services prescribed as part of a home health care plan.

Surgical — Medical Benefits

Our Plan pays 80% of reasonable and customary *doctor's charges* for these services:

services of a licensed physician, surgeon, specialist, chiropractor, psychiatrist, psychologist or certified social worker

in-hospital surgery

services of an assistant surgeon

cost of administering general anesthesia by a doctor other than your surgeon or his or her assistant

in-hospital visits

physical therapy — including massage, hydrotherapy, heat therapy and other similar treatments billed separately by a doctor while you're in the hospital

diagnostic laboratory and x-ray examinations

radiation therapy for inpatients — including most radium, radioactive isotope and x-ray treatments

Elective Procedures

A second confirming opinion or a third opinion (if the first two doctors disagree) from a Board Certified Specialist designated by Metropolitan is required in order to receive the regular Plan benefit (80% after the deductible) for the elective surgical procedures listed below. If a second confirming opinion is not received, the Plan will pay 50% of the reasonable and customary charge after the deductible is met.

appendectomies (non-emergency)

joint surgery (elbow, shoulders, hip and knee operations for treatment of arthritis)

cataract operations

cholecystectomies (gall bladder operations for purposes of exploration, draining or removal of gallstones)

deviated septum operations (non-cosmetic)

disk and spinal surgery

hemorrhoidectomies

hernia repairs

hysterectomies

prostate gland removal

surgical removal of uterine tube and ovary

tympanotomies (surgical puncture of the tympanic membrane of the ear)

tonsil and adenoid operations

vein ligation and stripping (for treatment of varicose veins)

Call toll free 1-800-451-4720 for the name of a Second Surgical Opinion Physician.

Emergency Care

After the onset of an illness or after an accidental injury, you and your covered dependents can receive benefits for the following:

- 80% of the reasonable and customary doctor's charges for necessary services performed at his or her office, the outpatient department of a hospital, or your home;
- 80% of the cost of all tests and supplies listed earlier under Hospital Benefits — available on an outpatient basis. This includes diagnostic laboratory and x-ray examinations;
- 80% of the cost of ambulance service in connection with a medical emergency or surgery performed in the hospital.

In the case of an accident these benefits are paid after the $200 accident benefit (described on page 4) has been used up.

Maternity Benefits

Maternity Benefits are provided under the Plan in the same manner as benefits for any other illness. They're available for female employees with Individual or Family Coverage and for the dependent wives of male employees who have enrolled for Family Coverage. Unmarried dependent daughters are also covered if you have Family Coverage.

Maternity benefits include:

- 80% of the cost of semi-private room plus hospital tests and supplies (as described under the Hospital Benefits section) during delivery or other pregnancy-related condition;
- the use of the delivery room and hospital nursery care charges for the newborn for up to 7 days during the mother's hospital stay. Well baby pediatric visits are not covered;
- 80% of maternity procedures performed at approved birthing centers;
- 80% of *all* reasonable and customary doctor's charges as described under the Surgical-Medical section. In addition to hospital benefits, coverage also includes customary prenatal and postnatal care for the mother;
- 80% of pregnancy complications.

Please note these additional important facts concerning maternity coverage:

Maternity benefits are provided for women who are already pregnant when they join the Plan as *new* employees (with either Individual or Family Coverage) and for the pregnant female dependents of *new*

male employees who have joined the Plan with Family Coverage.

In order for a newborn infant to be covered for illness or complications beyond usual nursery care, you must have Family Coverage before or within 31 days of the child's birth.

Alcoholism and Drug Addiction

Treatment for these disorders is covered as for any other illness, provided the detoxification center meets Metropolitan's definition of a "hospital" as noted in this booklet under "Some Definitions."

Other Medical Benefits

These services and supplies are also 80% covered:

services of registered nurses (provided they're not relatives or members of your household)

dressings, splints and plaster casts

plastic surgery necessary because of an accident while covered (plastic surgery for cosmetic purposes is excluded)

oxygen, anesthesia and their administration

blood and blood transfusions

rental (or purchase, if rental would be more costly) of an iron lung, hospital beds, crutches, wheelchairs and other durable equipment normally used for therapeutic purposes

diagnostic laboratory and x-ray examinations

artificial limbs and other prosthesis

physical therapy

prescription drugs

medical supplies

psychiatric treatment for you (employee) if you're totally disabled, and unable to work in any and every gainful occupation for which you are reasonably fitted by education, training or experience

psychiatric treatment for an eligible dependent during a hospital confinement for which room and board charges are actually made by the hospital

chemotherapy and radiation therapy

local professional ambulance service

physician office and home visits when due to illness or injury

Expenses 50% Covered

Surgery Without a Second Opinion

If a second opinion to confirm the necessity of certain elective surgical procedures listed on page 5 is not sought from a Board Certified Specialist designated by Metropolitan (or a third opinion in case the first two doctors disagree), *the Plan will pay only 50% of the covered expenses after the deductible has been met.*

Mental Illness or Functional Nervous Disorders

You and your covered dependents are eligible for payment on an outpatient basis toward doctors' services and prescription drugs necessary for treatment. The Plan pays 50% of the covered expenses once the annual deductible is paid. The maximum benefit payable per office visit is $25, ($50 maximum covered expense) and not more than $1,000 of benefits will be paid in a calendar year.

Maximum Benefits

You and each of your enrolled dependents can receive a maximum lifetime total of $500,000 in benefits under the Plan.

You can arrange to have the full maximum reinstated any time after the benefits charged to an individual's account reach a total of $1,000. You would, though, have to furnish proof the individual is in good health and it must be accepted by Metropolitan. For more information on what's required, contact the Employee Benefits Department, Group Insurance Section-New York Office.

Expenses Not Covered by the Plan

While the Plan covers a wide range of benefits, there are some services not covered, including:

- services which are not medically necessary or considered experimental in terms of generally accepted medical standards
- charges in excess of those considered reasonable and customary
- hospitalization mainly for diagnostic tests
- routine health check-ups
- medical care for any illness or injury covered by Workers' Compensation
- hospice and extended care facilities
- cosmetic plastic surgery *unless* due to an accident while covered
- dental expenses *unless* due to an accident while covered (treatment must be received within 12 months of the accident)
- doctors' visits and hospital room and board (beyond ordinary nursery care charges) for a newborn child *unless* you're enrolled for Family Coverage and the child is admitted as a bed patient independently of his or her mother
- all podiatry treatments are excluded unless an open cutting operation is involved
- eyeglasses or hearing aids, or examinations for them
- any services which are not performed by or recommended by a physician licensed to practice medicine
- personal, non-medical expenses such as phone bills and TV rentals while in the hospital
- any care provided free or reimbursed as the result of a legal action
- injuries due to an act of war
- experimental surgical procedures
- expenses submitted 2 years after the date of service
- services, supplies or treatment received before coverage is in effect or after it has been cancelled.

Some Definitions

Now that you know what the Plan pays for, we'll define some important terms.

"reasonable and customary charges"

The reasonable and customary charge is the lowest of:

The usual charge by the doctor or other provider of the services or supplies for the same or similar services or supplies; or

The usual charge of most other doctors or other providers of similar training or experience in the same or a similar geographic area for the same or similar services or supplies; or

The actual charge for the services or supplies.

"covered expenses" These are the reasonable and customary charges eligible for full or partial payment under the Plan. Some of the services ***not*** covered are listed on page 8.

"the deductible" This is the first $200 of all covered expenses in a calendar year for each covered person — which you must pay yourself. If you have Family Coverage, the most you'd have to pay is $200 per person or an aggregate maximum of $400 per family a calendar year, regardless of the number of people in your family who've received treatment.

If more than one member of your family is injured in the same accident, only *one* deductible of $200 will apply annually to the combined expenses resulting from the accident.

"carryover provision" Covered expenses ***being used to satisfy*** the deductible, incurred in the last three months of a year are also applied toward meeting the next year's deductible.

"Stop Loss provision" This feature sets an ***annual*** limit to the amount you have to pay ***out-of-pocket*** for all medical expenses covered by the Plan. After deductibles — $200 per person (maximum of $400 per family) have been met — and an additional $7,000 in covered medical expenses are incurred the Stop Loss provision takes over to stop further expense on your part. It will limit out-of-pocket expenses to $1,600 for someone with Individual Coverage and $1,800 for someone with Family Coverage.

If you meet the Stop Loss limit for expenses incurred during the last three months of any calendar year, you'll have 100% coverage under the Plan for the next year. An illustration of how the Stop Loss provision works can be found in example 3 on page 11.

Out-of-pocket expenses include the Plan deductible and the 20% share of the costs you pay under our Plan. Not included are such things as charges for non-covered services or any charges over the amounts determined reasonable and customary for your area.

"hospital" An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accrediation of Hospitals. Or any other institution which is operated pursuant to law, under the supervision of a staff of physicians and with 24 hour nursing service, and which is primarily engaged in providing general or specialized inpatient medical care.

Not included in this definition are nursing homes, convalescent facilities, alcohol or drug facilities, institutions for custodial care or those operated primarily as schools.

"physician/doctor" A licensed practitioner of the healing arts acting within the scope of his or her practice.

"ambulatory surgical center" A facility licensed by the state, equipped and run primarily for the purpose of performing outpatient surgical procedures. It is supervised by physicians and permits surgical procedures only by doctors who are licensed to perform surgery in at least one area hospital.

"home health care agency" An organization that supplies part-time nursing services in the home by a registered home or a licensed vocational nurse, and offers physical, speech, or occupational therapy. It

has a full-time administrator and maintains written records of services to patients. In order to qualify for payment under the Plan, home health care must be prescribed by the patient's doctor.

"birthing center" A center run primarily for treatment of pregnancy, including prenatal and postnatal care. It is directed by a doctor and has diagnostic x-ray and laboratory services. Defibrillator and blood bank services must be available through a hospital. For the locations of approved birthing centers, check with your local personnel representative.

"prescription drugs" The plan only covers drugs and medicines which require a prescription by a physican to dispense and are approved by the U.S. Food and Drug Administration for general use in treating the sickness or injury for which they are prescribed.

"You or Your" You or your means the employee who is the covered person for personal benefits. They do not include a dependent of the employee. Dependents are defined on page 3.

Some Examples of How the Plan Works

Example 1 Robert Kristy developed allergies which required continuing medical care. Here's what our Plan paid:

	Robert's bills	Plan pays	Robert pays
Family doctor (initial visit)	$ 50		
Diagnostic tests	$250		
Prescription drugs	$100		
Follow-up visits to doctor for treatments	$210		
	$610	$328	$282

- $610 was eligible for payment under our Medical Plan.
- After Robert paid a $200 deductible on the medical costs, 80% of the remaining $410 ($328) was paid by the Plan. This left a balance of $82.
- Robert utlimately paid $282 of the medical costs -- the $82 balance plus the $200 deductible.

Example 2 Shortly after she joined the Plan, Diana Hunter fell while running for a train and broke her leg. Even though the condition didn't require hospitalization, emergency care and follow-up treatments brought medical expenses to $1,180.

Here's how the costs were handled under the Plan:

	Diana's bills	Plan pays	Diana pays
Ambulance to hospital	$ 125		
Emergency room	$ 60		
Diagnostic x-ray	$ 75		
Doctor's treatment	$ 100		
Prescription drugs	$ 20		
Follow-up visits to specialist	$ 500		
Outpatient physical therapy	$ 300		
	$1,180	$824	$356

- Our Accident Provision paid the first $200 of Diana's bills in full, bringing the balance to $980.
- Diana paid the next $200 (the deductible) leaving a balance of $780. The Plan paid 80% of $780 ($624) which left $156 for Diana to pay. So she paid only $356 of the $1,180 total medical expense.

Example 3 After collapsing at home, Arnold Davis was taken to the emergency room of General Hospital. He was admitted when diagnostic tests showed he suffered a heart attack. His family doctor called in a heart specialist who arranged with a surgeon for open heart surgery. After 40 days in the intensive care unit and 36 days in a semi-private room, Arnold received hospital and doctor bills totalling $55,100.

Here's what our Plan paid:

	Arnold's bills	Plan pays	Arnold pays
General Hospital			
40 days of intensive care at $500 a day	$20,000		
36 days in semiprivate room at $200 a day	$ 7,200		
operating room	$ 2,000		
blood	$ 500		
recovery room	$ 750		
pharmacy	$ 1,000		
anesthesia supplies	$ 350		
respiratory services	$15,000		
Family doctor 30 visits at $20 each	$ 600		
Cardiac specialist 40 visits at $50 each	$ 2,000		
Surgeon	$ 5,000		
Anesthesiologist	$ 500		
Ambulance	$ 50		
Prescription Drugs	$ 150		
	$55,100	$53,500	$1,600

- After Arnold paid the deductible of $200, 80% of the next $7,000 of expenses ($5,600) was paid by the Plan. Arnold paid the difference ($1,400).
- The balance of his expenses of $47,900 was paid entirely by the Plan due to our Stop Loss provision.
- Arnold ultimately paid only $1,600 of his $55,100 medical bill.

How to Claim Benefits

Hospital Expenses You'll receive an identification card once you've enrolled in the Plan. Just present it when you're admitted and fill out the necessary paper work. Most hospitals require medical coverage information and forms authorizing direct payment of benefits to be completed at that time. The hospital then handles the claim process automatically. At the end of the hospital stay, you'd settle up for expenses not covered by the Plan. You will also receive notification of the final amount paid the hospital by the Plan.

Other Expenses Ask your supervisor or local personnel representative for a Medical Claim Form. Complete the "Employee Statement," add any appropriate dependent information, authorize direct payment, sign the form and return it to your doctor, the hospital outpatient department, ambulatory surgical center, birthing center, or home health care agency. They will complete the form and send it to Metropolitan for payment up to the Plan limits. You'd be responsible for any balance due.

Or you can pay your full bill and once your covered charges exceed the deductible, send an itemized bill along with the completed medical claim form to Metropolitan. Metropolitan will then reimburse you up to the Plan limits. To facilitate payment, try to submit your claims no later than 30 days after the end of the calendar year in which you incurred the expense. Claims older than 2 years cannot be considered or paid.

If You're Covered by Another Plan

With more two income families, it's possible you and your enrolled dependents are covered by separate employee programs with medical benefits. In this case, you must let each provider know about the coverage when you file a claim. This prevents more benefits being paid out than actual expenses incurred, and helps keep down increasing Plan costs — a portion of which you pay.

Plan means any plan providing benefits or services for or by reason of medical care or treatment, which benefits or services are provided by;

1) any group or blanket insurance plan, or any other plan covering individuals or members as a group;

2) any group hospital service prepayment plan, group medical service prepayment plan, group practice, or other group prepayment coverage;

3) any coverage under governmental programs, or any coverage required or provided by any statue, including any motor vehicle no-fault coverage required by statute.

If the plan provides benefits for you or a covered dependent which are later determined to be the legal responsibility of another person or company, the plan has the right to recover the cost of such benefit payments after the suit is settled. In such situations, you will be asked to sign an assignment of claim form.

Our Plan's "coordination of benefits clause" works this way. When a claim is made, the "primary" plan pays its benefits without regard to any other plan. The "secondary" plan(s) then adjusts its payments so the total benefits are not more than 100% of the allowable expenses.

Here's how "primary" and "secondary" plans are defined when all plans have a coordinating clause:

- The plan covering the patient directly (rather than as an employee's dependent) is considered primary; others are secondary.
- If a child is covered under both parents' plans, the plan of the parent whose birthdate (month and day) occurs earlier in the calendar year is primary.
- In the case of separation or divorce, a child covered by the plan of the parent to whom the court has decreed responsibility for the child's health care expenses is primary. Otherwise, the child is covered by plans in this order:

the plan of the parent having custody of the child;

the plan of the step-parent married to the parent with custody of the child;

the plan of the parent not having custody of the child.

- In circumstances other than these, the plan covering the patient longest is considered primary.
- A plan without a coordinating clause is always considered primary.

Coverage for Active Employees Over 65

Employees who continue working for the Company past age 65 and their spouses who are 65 and over may join Medicare (Parts A and B) in addition to or instead of the Medical Plan. When making your decision on the medical coverage you'll carry, you should consider the following:

- People age 65 and older with enough work credit under Social Security pay no premium for Medicare hospital insurance (Part A). If you're eligible you should apply for Part A coverage at any Social Security office three months before you reach age 65. You'll probably want to apply for Part A even if you're also covered under the Medical Plan, since Medicare Part A supplements our Plan at no additional cost to you.
- Medicare medical insurance (Part B) is voluntary and helps pay for doctors' services and many other health care services. If you choose to continue coverage under the Medical Plan, you may decide not to sign up for Medicare Part B. If you do sign up for both, you'll pay monthly Medicare premium *plus* your regular contribution to the Medical Plan.

However, if you do not enroll in Medicare Part B when you first become eligible at age 65, and later decide you want it, you'll have to pay a ten percent higher premium for each year you could have been enrolled but were not. Also, you can enroll late only during the months of January, February or March of any year, and your protection does not begin until July 1 of that year. This late penalty will not apply if you notify Medicare that you intend to continue working, and will again notify them when you stop work.

If you choose medical coverage under both our Medical Plan and Medicare, claims are first made to our Plan. Any covered expenses not paid by our Plan would then be eligible for payment under Medicare, up to the limits of the coverage provided. If you choose not to continue coverage under our Medical Plan, you won't have the option of being covered by the Medical Plan when you retire under the Retirement Plan. For more information contact the Employee Benefits Department, Group Insurance Section-New York Office.

When Your Employment Status Changes

Your employment status could change due to retirement, death, leave of absence or termination.

When You Retire

There are several arrangements for providing continuing medical coverage when you retire under the Retirement Plan. The type of coverage you have depends on your and your dependents' ages and the coverage in effect the day before retirement.

If you and your spouse are under 65: You can keep your current Individual or Family Coverage by continuing to pay the required contribution for "active" coverage.

Once you or your spouse reach 65: "Active employee" coverage under the Plan stops for the older individual. He or she should then enroll for Medicare coverage (Parts A and B). The person would then be covered by The Medicare Supplemental Plan providing the required contributions are made.

The younger partner can keep "active" coverage for himself or herself, plus any dependent children, by making the same contribution an active employee would pay. For more information on this subject, contact the Employee Benefits Department, Group Insurance Section – New York Office.

Death of Employee Not Eligible For Retirement Benefits

Your spouse and dependent children have the right to continue medical or HMO coverage in accordance with COBRA, see page 17 for further details. Also, see conversion privilege below.

Leave of Absence

If you're granted a long term leave of absence — for any reason other than military service — you can keep your coverage if you continue to make the required contribution.

Termination

If you resign or are released, your medical benefits remain in effect until the last day of the month in which your employment terminates. Under certain circumstances you and your dependents may continue coverage by paying the full premium. See the COBRA Section on page 17 for further information. Also, see conversion privilege below.

Extended Benefits

Benefits will continue if you or your enrolled dependent is totally disabled when coverage ends. Coverage is continued only for the disabled individuals. Covered expenses incurred in connection with the disability will continue to be paid — but never longer than the end of the next calendar year.

If you wish to be covered for all illnesses (not just the disability) you must enroll for continuation of coverage. See COBRA, page 17. Also see Conversion Privilege below.

Conversion Privilege Once benefits terminate, you'll have the opportunity to convert your coverage to an individual policy if you've been in the Plan for at least three months. This option is also available for covered dependents

under certain circumstances. This conversion can be obtained without providing proof of good health if you submit an application and premium payment to the Metropolitan Life Insurance Company or HMO within 31 days following termination of coverage. This converted policy is not part of the group plan and does not provide the same benefits.

For more information, contact the Employee Benefits Department, Group Insurance Section - New York Office or the Metropolitan Life Insurance Company at the address given in the Regulatory Information section of this booklet.

Effect On Employment

The Home Insurance Company Medical Plan does not give any employee a right to continued employment. Nor does it limit the right of an employer to terminate an employee at any time or to treat an employee without regard to the effect such treatment might have upon him or her as a participant in the Plan.

Regulatory Information

Plan Identification and Classification

The name of this Plan is The Home Insurance Company Medical Plan. It is a "welfare" plan which provides medical benefits for you and your covered dependents.

The Home Insurance Company, 59 Maiden Lane, New York, New York 10038 is the Plan Sponsor. The employer identification number (EIN) is 02-0308052. The business phone number is (212) 530-7000 — ask for the Employee Benefits Department, Group Insurance Section. The Plan Administrator is The Home Insurance Company Group Benefits Trust Committee:
The Home Insurance Company
Employee Benefits Department
59 Maiden Lane
New York, New York 10038.

The Plan is funded under The Home Insurance Company Group Benefits Trust and is administered directly by the Plan Administrator with benefits provided in accordance with the provisions of the group Plan. Claims are processed by:
Metropolitan Life Insurance Company
Group Medical Claims Office
P.O. Box 3009
Hauppauge, New York 11787-0856.
Funds are held in trust by:
The Chase Manhattan Bank, N.A.
1211 Avenue of the Americas
New York, New York 10036.

This booklet highlights the Plan. Some of the Plan's details have been simplified in this text due to their complexity. In the event of a discrepancy between this booklet and the actual plan documents, the terms of the documents will govern.

Legal Process

Legal process may be served upon:
The Home Insurance Company
Group Benefits Trust Committee
The Home Insurance Company
Benefits and Services Department
59 Maiden Lane
New York, New York 10038.

Plan Year

The Plan Year is a calendar year. The end of the Plan Year is December 31. All records are kept on that basis.

Claims

If any claim for payment under this Plan is wholly or partially denied, you'll receive a written notice explaining why, on which Plan provisions the decision was based or a request for any additional information necessary to consider the claim further. Questions may be directed to Metropolitan at (516) 348-1510. (This is not a toll free number.)

Claim Appeal Procedure

If you don't receive payment or notification of claim status from Metropolitan within 90 days of filing the claim or if the claim has been denied in whole or in part, you may file an appeal. If Metropolitan is unable to process your claim within 90 days, an additional 90 days may be taken by Metropolitan to respond. You'll receive written notification if this additional time is necessary by the end of the initial 90 day period.

To appeal a claim, write to The Plan Administrator within 60 days at this address:
The Home Insurance Company
Employee Benefits Department
59 Maiden Lane
New York, New York 10038.
The request for review should state the reasons why you believe the claim should be paid and can include additional information you feel may have a bearing on the matter.

You can ask the Plan Administrator to send you copies of pertinent documents and records. In some cases the Plan Administrator may require your approval before releasing confidential materials such as medical reports.

The Plan Administrator will review the claim and provide a written response within 60 days, explaining the specific Plan provisions on which the decision was based. If the Plan Administrator is unable to respond within 60 days an additional 60 days may be taken by the Plan Administrator to respond. You'll receive written notification if this additional time is necessary by the end of the initial 60 day period. The Plan Administrator has the exclusive right to interpret the provisions of the Plan, so its decision is binding.

Participating Companies

A complete list of participating employers is available for inspection any time during regular working hours at:
The Home Insurance Company
Employee Benefits Department
59 Maiden Lane
New York, New York 10038,
and at certain other locations. You may obtain a copy of this list by submitting your written request to the Plan Administrator. There may be a reasonable charge involved for this service.

The Plan is designed for all full-time employees of the participating companies. The Plan Identification Number is 599. Questions regarding the Plan should be directed to the Plan Administrator.

The Plan's Future

The Home expects and intends to continue the Medical Plan indefinitely, but reserves the right to amend or end it if this is considered necessary or desirable.

Your rights as a Plan participant under The Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA provides for continuance of group medical and HMO coverage for qualified Beneficiaries when a qualifying event occurs as described below.

Qualifying Event	Qualified Beneficiary	Period For Continuation Of Coverage
Termination Of Employee (except for gross misconduct)	Employee and Family	18 months
Reduction in Employee's Hours which enables cancellation	Employee and Family	18 months
Death Of Employee	Spouse and covered Child(ren)	36 months
Divorce	Spouse and Child(ren)	36months
Legal Separation	Spouse and Child(ren)	36 months
Employee Eligible For Medicare	Spouse and Child(ren)	36 months
Child(ren) Ceasing To Be "Dependent"	Child(ren)	36 months

Please notify The Home Insurance Company, Employee Benefits Department, 59 Maiden Lane, New York, New York 10038 within 60 days if you become divorced or legally separated. If your dependent child ceases to be a dependent you must also inform the Employee Benefits Department within 60 days. Or, if later within 60 days of the date the qualified beneficiary would lose coverage on account of that event. You will then be given the forms that must be completed to continue coverage.

The qualified beneficiary who chooses to continue coverage is responsible for completion of necessary forms and payment of the full group medical rate plus 2% for administrative fees. The grace period for the failure to pay premiums is 30 days after the due date.

The Law also provides that your continuation coverage may be cut short for any of the following reasons:

(1) The participating Companies no longer provide group health coverage to any of their employees;

(2) The premium for your continuation coverage is not paid;

(3) You become an employee covered under another group health plan;

(4) You become eligible for Medicare;

(5) You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

Your rights as a Plan participant Under the Employee Retirement Income Security Act (ERISA)

As a participant in the Plan, you're entitled to certain rights. For example, you received this booklet describing the Plan and its provisions. You have the right to receive a summary of the Plan's annual report which the Plan Administrator is required to distribute by law.

You also have the right to examine without charge, or to obtain copies of all documents relating to the Plan. All Plan documents, including those filed with governmental agencies are available for inspection any time during regular working hours at The Home Insurance Company, Employee Benefits Department, 59 Maiden Lane, New York, New York 10038 and at certain other locations. Copies of these items will be made available if you write to the Plan Administrator requesting them. There may be a reasonable charge involved for this service.

The people who operate this Plan (called the "fiduciaries") have a duty to do so prudently and in the interests of all Plan participants and beneficiaries. To further ensure that all employees are treated fairly, the law provides that no employer can fire or discriminate against employees to discourage them from exercising their rights under the Plan or prevent them from getting their benefits.

If any part of your benefits is denied, you must receive a written explanation of the reason. You have the right to have the Plan Administrator review and reconsider your claim.

If the Plan Administrator fails to furnish within 30 days documents you've requested in writing—unless the materials weren't sent because of matters beyond the control of the Administrator—you have the right to file suit in a federal court.

The court may require the Plan Administrator to provide the materials and pay up to $100 a day until you receive them.

If you have been improperly denied a benefit in whole or in part, you may file suit in a state or federal court. If the Plan fiduciaries misuse the Plan's money or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're 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. This could happen, for example, if the court finds your claim frivolous.

If you have any questions about this Plan, this Summary Plan Description, or your rights under ERISA, check with the Employee Benefits Department at the New York Office of:
The Home Insurance Company
59 Maiden Lane
New York, New York 10038
(212) 530-7000
They'll be glad to help. If you wish, you may contact the nearest office of the U.S. Labor Management Services Administration, Department of Labor.

9/18/03
date sent
Overnight
mail

Letter to Home's Disabled Employees from The Home Insurance Co. in Liquidation

On August 29, 2003 a letter was sent to you from The Home Insurance Company In Liquidation (the "Company") advising you that as a result of the liquidation of The Home Insurance Company your employment with the Company was terminated effective September 1, 2003. In addition, the letter informed you that as a result of The Home's insolvency, the Company is unable to continue to pay its portion of welfare benefits (medical, dental, and life) for individuals with disability-related benefits. Therefore, your Home-funded disability-related welfare benefits as well as any AD&D coverage you may carry through the Company will terminate effective September 30, 2003. This follow-up communication is being sent in order to address the various questions and concerns that have been received in response to the initial letter.

COBRA ELIGIBILITY:

You are not eligible for COBRA because your health benefits coverage was already continued for more than 29 months since your last day of active employment. COBRA regulations require the continuation of medical and dental benefits if an employee experiences a qualifying event, which results in the loss of coverage. In order for COBRA to apply, there must be a reduction in employment hours and the medical and dental benefits coverage must be terminated before the end of the required minimum period of 18 or 29 months. Your disability status meets the requirement of reduction in hours and your benefits were continued beyond the required period mentioned above.

CONVERSION OF BENEFITS:

Life Insurance - Coverage under this plan will terminate effective September 30, 2003. A Conversion of Group Term Life Insurance form is attached. It is recommended that you contact Aetna Life Insurance at (800) 523-5065 to request conversion premium costs for Group-720385 Home Disabled.

Medical Coverage - is provided by two providers; United Healthcare, UHC-POS Insured Policy #192962-001 (Phone 1-866-747-1019) and Aetna HMO policy #002432A0000 Phone (1-800-323-9930). Please call your provider to request conversion premium costs and a conversion form. Remember that your last day of coverage under the existing plan is September 30, 2003.

Dental Coverage - The last day of coverage for this benefit is September 30, 2003. There are no conversion benefits available.

AD&D - The last day of coverage is September 30, 2003. If you had purchased this coverage a conversion form with rates is attached. If you wish to convert this coverage to an individual plan simply complete and mail it to the address on the form.

Questions regarding the above-listed coverages may be directed to Peg Brady who is assisting us on these matters at 212-898-8727. All other questions should be referred to Sally Goldberg at 603-634-0147.

Benefits Bulletin

Risk Enterprise
Management
Limited
59 Maiden Lane
New York, NY 10038

REM Risk Enterprise Management Limited

To
Home Insurance Company
Long Term Disabled Employees

From
Benefits Department

Date
December 2, 1996

Re
1997 Medical Coverage

We are writing to let you know about a significant change we are making effective January 1st to your medical coverage as a long term disabled employee of Home Insurance Company. If you and/or your covered dependents are enrolled in either the Home's Medical Plan or in the MetraHealth HMO in any state except New York, you must make a new election for medical coverage in 1997. If you do not make a new medical coverage election and you are currently enrolled in either one of the aforementioned plans, effective January 1st, you will automatically be enrolled under the new "Point-of-Service" Plan discussed below and a primary care physician will be assigned to you until you make a election. Here are the details:

Medical Coverage

Beginning January 1, 1997 Home's Medical Plan will change from a traditional "indemnity" plan to a "Point-of-Service" (POS) Plan insured through United HealthCare (the new name for MetraHealth). In addition, the MetraHealth HMO will be cancelled in all states, except New York.

The decision to switch from a traditional indemnity plan to a POS Plan resulted from our analysis of the unusually high claim costs in 1996. The study indicated that the indemnity plan needed to be more aggressively managed and that the POS Plan provided the most effective and attractive alternative to accomplish that objective. Also, because of the size of the covered group in the current indemnity plan, we decided to change the Plan from a self-insured arrangement to an insured arrangement with United HealthCare.

Consequently, there will be an increase in your 1997 contribution for medical coverage based on a combination of the poor claim experience in 1996 and the cost to insure the coverage. As in the past, the company continues to share the cost of this coverage with you.

The New Point of Service (POS) Plan

The new POS Plan combines the flexibility of a traditional indemnity plan by allowing you to use any doctor, hospital or pharmacy *and* it provides the cost-savings of an HMO through the POS "network" of health care providers. It is as though you are covered by both an indemnity plan (out-of-network) and an HMO (in-network). Here is how it will work for those of you who enroll in the POS Plan.

Each time you need a doctor, hospital or pharmacy you will decide whether to go inside or outside the network. The network consists of doctors, hospitals and other health care providers who have agreed to pre-determined rates for POS Plan participants. United HealthCare sets the in-network costs so you know they will be within the Plan's limits. Generally, in-network costs are lower than out-of-network costs. As with any medical plan with in-network providers, you'll need to choose your main doctor, or Primary Care Physician (PCP).

When you go inside the network, you can receive coverage for "preventive-type" services not available in most indemnity plans. These include services such as routine annual physicals, immunizations and gynecological screenings, as well as mammograms and other outpatient diagnostic services. In most cases, your in-network cost for services is only $10 for each doctor's visit or for each diagnostic test. You will also benefit from a prescription drug program that charges $5 for generic drugs and $10 for brand name drugs at network pharmacies.

When you go outside the network, deductibles, out-of-pocket maximums and reasonable and customary limits (R&C) apply as is currently true for the Home Medical Plan. The POS Plan will pay 100% of the R&C charges for covered services once you have reached the annual out-of-pocket maximum. Deductibles and annual out-of-pocket maximums vary depending upon the coverage level you choose and are listed on the next page.

The POS networks cover most of Home's long term disabled employees. However, if you are not covered, you will have to be covered by the out-of-network benefits of the POS Plan, or an HMO if available in your area.

Other Changes

The POS Plan's out-of-network coverage provides the same or substantially the same, benefits as were provided under the previous Home Medical Plan. That is, out-of-network coverage is comparable to what the current indemnity plan provides to participants who are not in an HMO. However, effective January 1, 1997, the following changes will be made to the out-of-network coverage:

- **Annual deductibles will increase to:**
  - **$400 for individual coverage**
  - **$800 maximum for disabled employee and one dependent coverage ($400 per individual)**
  - **$1,200 maximum for family coverage ($400 per individual, maximum of 3 family members)**
- **The out-of-pocket maximum, or highest cost you can incur in a single year before the POS Plan pays 100% of your covered expenses will increase to:**
  - **$2,500 plus annual deductible for individual coverage**
  - **$5,000 maximum (limited to $2,500 per individual) plus annual deductibles for disabled employee and one dependent coverage**
  - **$7,500 maximum (limited to $2,500 per individual, maximum of 3 family members) plus annual deductibles for family coverage**

If you have any questions about how the POS Plan works, your medical coverage generally, or how to complete your enrollment form for 1997, please contact Celia Kruzik in the Benefits Department at (212) 530-6072 during normal business hours.

Medicare Coverage

If you have been entitled to Social Security benefits for 2 years, you are eligible for primary medical coverage under Medicare and should be enrolled for both Medicare Parts "A" and "B". In these cases, you will not be covered under the new POS Plan. Instead, you will continue to be covered primary under Medicare and the company plan will continue to act as secondary payer. If your spouse and/or dependent children are enrolled for coverage in the current indemnity plan, their coverage will be switched from the indemnity plan to the POS Plan and you must return an enrollment form to us by December 12. Please indicate a choice of a POS Plan primary care physician on the enrollment form for each of your dependents. A new member identification card will be issued for your dependents.

HMOs

As an alternate to the POS Plan, you may elect to join any of the HMOs currently offered in your geographical area including the MetraHealth HMO in New York. The changes described

previously only affect the current indemnity plan. HMO contributions vary by HMO and in most cases are slightly higher in 1997. If you are interested in joining any of the HMOs listed on the enclosed rate sheet for which you are eligible, please call Celia Kruzik in the Benefits Department at (212) 530-6072 for additional information.

Dental Coverage

As you know, the Dental Plan was substantially improved in 1996. The same Plan continues in 1997. As in the case of the medical plan, the company will insure this coverage in 1997. As a result, the increase in your 1997 contribution is based on the cost to insure the coverage and the heavy utilization of the Plan in 1996. As in the past, the company continues to share the cost of this coverage with you.

Enrollment

Enclosed is a provider directory listing United HealthCare primary care physicians and specialists in your geographical area. A POS Plan enrollment form and a rate sheet are also enclosed. Please complete your enrollment form no later than December 12 and mail it to Celia Kruzik at the address previously provided. If you wish to join an HMO, the HMO enrollment form will be included in the HMO materials which will be forwarded to you upon request. The rate sheet details the 1997 contributions for the POS Plan, the various HMOs and the Dental coverage.

Your contributions for 1997 will be effective with your January check. If you are currently in the Home Medical Plan, or the MetraHealth HMO in all states except New York, and do not make a new medical coverage election we will assume that you have elected the new POS Plan. If you wish to change your coverage or cancel coverage, please inform us in writing as soon as possible. If we receive your change by December 12, 1996 we will make the adjustment in your February 1997 pension check.

If you pay your medical contributions to us directly, please refer to the attached memorandum with payment instructions effective in 1997.

It is extremely important, if you are enrolling in the new POS Plan or an HMO for the first time that you return your enrollment form to us as soon as possible. Please note that if you do not return your POS Plan enrollment form or indicate your choice of a POS Plan primary care physician on the enrollment form, United HealthCare will issue you an identification card and assign a primary care physician. You may change this doctor at any time by calling United HealthCare at the telephone number printed on your member identification card.

In the case of an HMO, no benefits are available without your election of a primary care physician.

We are confident that these changes will continue to provide you with high quality and affordable medical coverage. If you have any questions about your choices or the enrollment process, again please contact Celia Kruzik in the Benefits Department at (212) 530-6072.

The company reserves the right and discretion to amend, modify, change or terminate each benefit plan cited herein for any reason or at any time with respect to actively employed or former employees, their dependents and beneficiaries.

Home

1997 MEDICAL/HMO AND DENTAL RATES

'ted below are the rates, per month, for Home's Medical Plan, current HMO plans and Dental Plan effective January 1, 1997.

	STATES	EMPLOYEE ONLY	EMPLOYEE PLUS 1	EMPLOYEE PLUS 2
DENTAL	ALL	$8.84	$17.16	$29.62
HOME'S MEDICAL PLAN (METRAHEALTH)	ALL	$60.80	$149.72	$224.54
CIGNA	CO	$38.78	$88.64	$130.20
GRAND VALLEY HEALTH PLAN	MI	$31.00	$89.72	$98.24
HEALTHAMERICA	PITTSBURGH	$34.12	$85.40	$116.22
'ALTH INSURANCE PLAN (HIP)	NY,NJ	$34.58	$73.94	$112.20
HEALTHSOURCE	NH	$44.02	$100.14	$139.06
HMO BLUE	NJ	$42.34	$99.38	$139.06
HMO-CNY (IPHP)	SYRACUSE	$39.24	$95.98	$123.90
KAISER	DALLAS	$26.98	$61.36	$94.68
KAISER	KS	$29.96	$68.18	$105.20
KAISER	N. CALIF	$31.38	$71.36	$97.64
KAISER	N. CAROLINA	$37.90	$86.24	$124.20
EDICA	MN	$44.64	$115.48	$163.56

	STATES	EMPLOYEE ONLY	EMPLOYEE PLUS 1	EMPLOYEE PLUS 2
METRAHEALTH COUNTRYWIDE	*SEE BELOW	$44.26	$101.00	$148.60
METRAHEALTH HMO-NY	NY	$37.58	$81.90	$136.00
OXFORD HEALTH PLANS	NY,NJ,CT,PA	$42.60	$100.24	$149.50
PACIFICARE	S. CALIF	$33.92	$73.44	$110.28
PCA HEALTH PLANS OF ALABAMA (S.E. HEALTH)	BIRMINGHAM	$39.78	$100.16	$145.90
PHYSICIANS HEALTH SERVICES	NY, CT	$41.02	$94.20	$140.16
E-PAID HEALTH PLAN	SYRACUSE	$30.40	$69.14	$98.46
PRIORITY HEALTH PLAN	MI	$34.16	$99.02	$108.52
PRUDENTIAL HEALTHCARE	NASHVILLE	$34.58	$78.66	$112.06
PRUDENTIAL HEALTHCARE	ORLANDO	$28.04	$65.36	$103.86
US HEALTHCARE	*SEE BELOW	$37.02	$80.98	$126.76

*METLIFE NETWORK IS AVAILABLE IN THE FOLLOWING STATES:
AZ, CA, CO, CT, FL, GA, IL, KS, MA, OH, TX, WI, RI
S HEALTHCARE IS AVAILABLE IN THE FOLLOWING STATES:
,DC,DE,GA,MA,MD,NH,NJ,NY,PA

Benefits Bulleti

Risk Enterprise Management Limited
59 Maiden Lane
New York, NY 10038

R·E·M.®

To: All Inactive Employees in Disabled status of Zurich Risk Management Services (US) Risk Enterprise Management Limited and The Home Insurance Company

From: Benefits Department

Date: September 16, 2002

Re: **RETIREE BENEFIT CHANGES**

Retiree Medical Coverage

The retiree medical benefit is being eliminated for employees and their eligible dependents who retire after November 1, 2002. This benefit will continue for Early Retirees (under age 65) and Normal Retirees (age 65 or older) who either (i) are currently receiving the benefit or (ii) who would be eligible under the current provisions of the Medical Plan to receive the benefit provided they retire on or prior to November 1, 2002. **Employees who retire after November 1, 2002 will no longer be offered this benefit.**

An employee hired by The Home Insurance Company prior to January 1, 1990, who meets all of the eligibility requirements for the **Early Retiree** (under age 65) medical benefit, and who retires on or prior to November 1, 2002 may continue the same medical coverage as he or she had as an "Active Employee" for himself and for any eligible covered dependent by paying the amount of the required contribution. This required contribution is the same amount paid by an active Risk Enterprise Management Limited employee. **Normal Retirees** (age 65 or older) may enroll in the Medicare Supplemental Program and pay 100% of the premium provided that the retirement date is November 1, 2002 or earlier. Eligible dependents under age 65 of Normal Retirees, who retire on or prior to November 1, 2002, may continue the same medical coverage by paying the amount of required contribution. This required contribution is the same amount paid by an active Risk Enterprise Management Limited employee.

An employee hired by The Home Insurance Company on or after January 1, 1990, who meets all of the eligibility requirements for the **Early Retiree** (under age 65) medical benefit, and who retires on or prior to November 1, 2002 may continue the same medical coverage as he or she had as an "Active Employee" for himself and for any eligible covered dependent by paying the full amount of the required contribution. This required contribution is 100% of the premium cost for such coverage. **Normal Retirees** (age 65 or older) may enroll in the Medicare Supplemental Program and pay 100% of the premium provided that the retirement date is November 1, 2002 or earlier.

Any employee who retires after **NOVEMBER 1, 2002** will **not** be eligible for any Retiree medical coverage. In these cases, COBRA provides for continuation of group medical coverage for early retirees and/or dependents.

The Company reserves the right and discretion to amend, modify, change or terminate medical coverage for any reason or at any time with respect to actively employed, inactive employees in disabled status, early retirees, retirees, their dependents and beneficiaries. **The Retiree medical coverage benefit will be terminated in the event and at the time The Home Insurance Company ceases to reimburse REM for the cost of this benefit.**

Life Insurance

Under the current Life Insurance Plan, if you were an employee of The Home Insurance Company who was enrolled in The Home Insurance Group Life Insurance Plan for supplemental personal life insurance of at least one times your salary and were age 50 or older on January 1, 1989, you are eligible at retirement from Risk Enterprise Management Limited for free post retirement life insurance coverage for yourself. All other employees are not entitled to company paid life insurance coverage at retirement; however, conversion coverage is available.

Free post retirement **life insurance** coverage as described in the Employee Benefits Program or in the letter provided at the time of retirement, **will be continued at the present time. Please note, however, this benefit will be terminated in the event and at the time The Home Insurance Company ceases to reimburse REM for the cost of this benefit.**

A copy of the Medical and Life Insurance Plan changes are attached.

If you have questions about your medical coverage you may call (212) 530-6072 or 6972

Benefits Bulletin

Risk Enterprise Management Limited
59 Maiden Lane
New York, NY 10038

R E M.®

To: Home Insurance Company Inactive Employees in Disabled Status Not Approved for Medicare Coverage

From: Benefits Department

Re: November 11, 2002

Re: **2003 Employee Benefits Program**

As you know, each year at this time we write to you to let you know about changes in the Employee Benefits Program for the coming year and to inform you of any changes in cost for your elected benefits.

During 2002, the Point-of-Service (POS)/Preferred Provider Option (PPO) Medical Plan for inactive employees and/or dependents under age 65 which is fully insured with United HealthCare experienced decreased enrollment and increased claims submitted for payment. This claims experience combined with increased prescription costs, high medical inflation trends and lower enrollment, resulted in an unfavorable renewal. As a result, in 2003, United HealthCare has raised the current rates by 17% for the POS/PPO Plan. The new rates are effective January 1, 2003.

HMO contribution rates vary by HMO and are also higher in 2003.

As in the past, The Home continues to share the expense of medical coverage by paying approximately 76% of the total cost.

Due to regional HMOs reducing their service areas and/or substantially increasing their rates, please confirm with your provider that your zip area continues to be offered in 2003.

Following is a brief description of the 2003 Medical, Dental Assistance Plan and HMO coverages:

Medical Coverage for Inactive Employees in Disabled Status

In 2003, Home will continue to provide United HealthCare's Point-of-Service (POS) Plan as a medical coverage option. The POS Plan combines the flexibility of a traditional indemnity plan with the cost-savings of an HMO. Each time you need medical care, you can decide to use any accredited doctor, hospital or pharmacy *or* use the POS "network" of health care providers. It is as though the out-of-network coverage acts as your indemnity plan and the in-network coverage acts as your HMO. The POS network includes doctors, hospitals and other health care providers who have agreed to pre-determined rates for POS Plan participants.

United HealthCare sets the in-network costs; generally, in-network costs are lower than out-of-network costs. As with any medical plan with in-network providers, you'll need to choose your main doctor, or Primary Care Physician (PCP). *For a listing, call United HealthCare at 1-800-251-2616 or you may use the internet at www.uhc.com.*

When you go inside the network, you can receive coverage for "preventive-type" services not available in most indemnity plans. These include services such as routine annual physicals, immunizations and gynecological screenings, as well as mammograms and other outpatient diagnostic services. In most cases, your in-network cost for services is only $10 for each doctor's visit or for each diagnostic test.

When care is provided outside the network, deductibles, out-of-pocket maximums and reasonable and customary limits (R&C) apply. The POS Plan will pay 100% of the R&C charges for covered services once you have reached the annual out-of-pocket maximum. Deductibles and annual out-of-pocket maximums vary depending upon the coverage level you choose.

The following chart compares the in-network and out-of-network deductibles, co-payments and out-of-pocket maximums, as well as the prescription drug benefits available both in-and out-of-network:

	COVERAGE UNDER POINT-OF-SERVICE PLAN	
	In-Network Coverage	Out-of-Network Coverage
Annual Deductible	None	$400 per covered individual, maximum $1,200 per family
Out-of-Pocket Maximum	None	$2,500 per covered individual plus annual deductible, $7,500 maximum per family plus annual deductibles
Office Visit Co-Payment	$10 per visit	20% of the reasonable and customary charges for covered services after satisfaction of annual deductible
Prescription Drugs	$7 generic/$12 approved brand name/$25 non-approved drug for a 30-day supply	$7 generic/$12 approved brand name/$25 non-approved drug for a 30-day supply
Mail Order	$14 generic/$24 approved brand name/$50 non-approved drug for a 90-day supply	$14 generic/$24 approved brand name/$50 non-approved drug for a 90-day supply
Lifetime Maximums will continue for out-of-network benefits.		

Because state insurance laws are different in the states of New York, New Jersey and Texas participants residing in these states will notice slight differences from the above schedule. (i.e. Emergency Room co-pay, Out-of-Network deductible, Out-of-Pocket maximum and mail order prescriptions (NJ). If you have any questions about these differences you may call United HealthCare member services at 1-800-251-2616 or Celia Kruzik at 212-530-6072.

Some participants reside outside the United HealthCare service area. In those cases, the coverage available is the Out-of-Network coverage (POS). If a Preferred Provider Option (PPO) network is available in your area the Plan works the same as the POS "Out-of-Network", except, the participating providers have agreed to accept a lower fee for their service. For example, if you reside outside the POS Plan area and there is a PPO provider in your area if the normal charge for a service is $50 and the PPO provider has agreed to accept $40 the Plan pays 80% of the $40 or $32. Your out-of-pocket expense is $8 as opposed to the POS "Out-of-Network" which pays 80% of the $50 resulting in a $10 out-of-pocket expense. If you reside outside the POS Plan area, please call United HealthCare for a listing of PPO providers at 1-800-251-2616 or you may use the internet at www.uhc.com.

Your 2003 contribution for the POS/PPO Plan will be approximately 17% higher than the current cost based on claims experience during 2002. (See enclosed rate sheet.)

HMOs

As an alternate to the POS/PPO Plan, you may elect to join any of the HMOs currently offered in your geographic area. HMO contributions vary by HMO and in all cases are higher in 2003. If you are interested in joining any of the HMOs for which you are eligible as listed on the enclosed rate sheet, please call the 800 number or the internet website to determine if your doctor participates. Then call Celia Kruzik at 212-530-6072 for an enrollment form.

Dental Coverage

The Dental Assistance Plan continues in 2003. As a result of favorable claims experience in 2002, there will be no increase in your contribution in 2003.

Enrollment

If you wish to join the POS/PPO Plan or an HMO contact Celia Kruzik at the telephone number listed above for enrollment forms. (If you enroll in an HMO, all family members will be enrolled in the same HMO and vice versa.) Please complete your enrollment form no later than December 6, 2002 and mail it to Celia Kruzik at Risk Enterprise Management Limited, Benefits Department, 17th Floor, 59 Maiden Lane, New York, NY 10038.

If you pay your contributions directly, please continue to send your payment to our administrator, Travers, O'keefe at 11 Hanover Square, 22nd Floor, New York, NY 10005 by the 1st day of each month.

It is extremely important, if you are enrolling in the POS/PPO Plan or an HMO for the first time that you return your enrollment form to us as soon as possible. No benefits are available without your election of a Primary Care Physician.

If you have any questions about your choices or the enrollment process, again please contact Celia Kruzik in the REM Benefits Department at 212-530-6072.

The company reserves the right and discretion to amend, modify, change or terminate each benefit plan cited herein for any reason or at any time with respect to actively employed, inactive or former employees, their dependents and beneficiaries.

2003 MEDICAL AND RMO RATES: HOME INSURANCE COMPANY

Listed below are the monthly rates for retirees under age 65 and Inactive Employees in Disabled Status (Non Medicare Eligible) for Home's Medical Plan and the current 10 plans effective January 1, 2003

	STATES	EMPLOYEE ONLY	EMPLOYEE PLUS 1	EMPLOYEE PLUS 2
DENTAL (DISABLED STATUS ONLY)	ALL	$10.06	$19.41	$33.41
HOME'S MEDICAL PLAN (UNITED HEALTHCARE) 1-800-527-6778 *www.uhc.com*	ALL	$202.64	$438.70	$639.60
AETNA US HEALTHCARE 1-800-323-9930 *www.aetnaushc.com*	NJ, NY	$83.86	$167.54	$240.40
HEALTH INSURANCE PLAN (HIP) 1-800-447-8255 *www.hipusa.com*	New York	$63.54	$116.02	$184.70
HEALTHNET (PHS) 1-800-441-5741 *www.health.net*	NY, NJ, CT	$84.86	$171.34	$250.92
OXFORD HEALTH PLANS 1-800-444-6222 *www.oxfordhealth.com*	NY, NJ, CT	$84.34	$179.04	$252.98
PACIFICARE 1-800-624-8822 *www.pacificare.com*	California	$58.16	$122.10	$174.44

NOTE: ALTHOUGH COVERAGE IS AVAILABLE IN THE STATES LISTED ABOVE, IT MAY NOT BE AVAILABLE IN ALL AREAS OF EACH STATE -- PLEASE CALL THE NUMBER LISTED TO CONFIRM THE SERVICE AREA.