

MESSAGE FROM THE TRUSTEES

Dear Retiree:

We are pleased to present you with this booklet, also called a Summary Plan Description, which summarizes the benefits provided by the District Council 37 Health & Security Plan (the “Plan”). This booklet also explains how to determine whether you are eligible for benefits and how to submit claims in order to receive benefits. In addition, it provides you with an explanation of your rights and responsibilities.

The primary purpose of this booklet is to provide you with a non-technical explanation of the most important features of the benefits. It is not a substitute for the official Plan documents that set forth the details of the benefits provided by the Plan. Accordingly, this Summary Plan Description does not change or otherwise interpret the terms of the official Plan documents, such as the trust agreement under which the Plan is established, and agreements with providers of benefits under the Plan’s trust agreement. Your rights can be determined only by referring to the full text of these official documents, which are available for your inspection at the Plan Office. Please note also that no one (other than the Board of Trustees) has the authority to interpret the Plan (or official Plan documents) or to make any promises to you about it.

This Summary Plan Description has no legal force or effect-only the formal Plan documents themselves actually govern the operation of the Plan and the benefits to which you (and/or, if applicable, your dependents) may be entitled. This booklet is supplied solely for the purpose of assisting you in comprehending the scope and meaning of the Plan, and is not intended to interpret, replace, or amend the Plan. To the extent that any of the information contained in this booklet is inconsistent with the official Plan documents, those documents will govern in all cases.

Your particular attention is directed to the various deadlines for filing claim forms in order to obtain benefits. These deadlines, which are strictly applied, are set forth on page 35.

We also call to your attention that the Trustees have the authority, in their sole and absolute discretion, to amend, modify or terminate the Plan at any time, and the sole and absolute discretion to interpret the Plan provisions and all official Plan documents. Please see page 47 for more information concerning this authority.

We hope that you will review this booklet carefully and share it with the members of your family, since many of the benefits described are also available to your eligible dependents. Familiarity with what is available to you under the Plan will help to ensure that you make the best possible use of the benefits to which you are entitled.

After reading this booklet, if you have questions concerning the benefits to which you are entitled, please feel free to contact the Health & Security Plan’s Inquiry Unit telephone number, (212) 815-1234 or the Municipal Employees Legal Services’ telephone number (212) 815-1111.

Please note that some of the benefits provided hereunder, such as Legal Services, may be subjected to income tax. You should consult with your income tax advisor if you have any questions with respect to the taxation of such benefit as the Trustees make no representations as to the tax consequences to you of your Plan participation.

In addition to providing a plan of benefits which is responsive to your needs, the Trustees continually evaluate and explore new ways of providing benefits and services. Our goal is to see that our members receive benefits of the broadest nature possible and that the services delivered are both cost effective and high quality. We hope this booklet will assist you in understanding these benefits and that through your assistance as “an informed consumer” the excellent package of benefits offered will be viable into the future.

In Solidarity,

District Council 37 Benefits Fund Trust

Lillian Roberts
Chair

Oliver Gray
Trustee

Maf Misbah Uddin
Secretary-Treasurer

Dated: January 2008

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WHO IS ELIGIBLE FOR THESE BENEFITS?

You are eligible for the benefits described in this booklet if you meet the eligibility requirements listed below and were employed by one of the following employers in a title covered by a collective bargaining agreement or a comptroller's determination which provides for a contribution to be made on your behalf:

Brooklyn Public Library
City of New York (Mayoral Agencies)
City University of New York
Educational Opportunity Centers
Office of Court Administration
New York City Department of Education
New York City Health & Hospitals Corporation
New York City Housing Authority
New York City Off-Track Betting Corporation
New York City School Construction Authority
New York City Transit Authority
New York State Rent Regulations Services Unit
Queensborough Public Library
Triborough Bridge and Tunnel Authority

You are eligible for the benefits described in this booklet if you meet the eligibility requirements and were represented by one of the following:

Local 371 - Social Services Employees Union (SSEU)
Law Assistant Associates - LAA
Marine Engineers Beneficial Association - MEBA
Municipal Guild of Radio and Television Technicians (MGRTVT)

The following sections describe the criteria for retiree benefits and the benefits available to each group. Please note that if you were hired on or after 9/1/1995, you must be a member of the NYC Employees' Retirement System, Department of Education Retirement System or the Teachers' Retirement System and qualify for a pension to be eligible for any of the benefit packages offered by the Plan. If you have questions about your eligibility and which benefit package you are entitled to, call the DC 37 Health & Security Plan's Inquiry Unit at 212-815-1234 or the toll free retiree number at 1-877-323-7738.

I. PENSIONABLE FULL-TIME RETIREE ELIGIBILITY REQUIREMENTS

In order to qualify for the Former Full-Time Employee Health and Security Plan Benefits package as a retiree, you must satisfy all of the following requirements:

1. You had to retire subsequent to June 30, 1970;
2. You had to be in a full time title covered by the DC 37 Welfare Fund or in a title covered by contractual agreement at the time of retirement;
3. You had to have the minimum required years in the New York City Employees' Retirement System or a similar retirement system at the time of separation from the Employer;
4. You had to remain a primary beneficiary of the Employer's paid health insurance program or provide a copy of your waiver of Employer's paid health insurance; and
5. You must be receiving a pension.

If you meet all of the above requirements, the following benefits will be available to you and your eligible dependents:

Health and Security Plan Benefits available to you (the retiree) and your dependents:
Dental Benefit

Prescription Drug Benefit *
Vision Care Benefit including Supplemental Optical Benefit
Health and Pension Counseling
Second Surgical Consultation
Social Service Crisis Intervention (Personal Service Unit)
Survivor Benefit
Municipal Employees Legal Services Benefit¹

*Former employees of the Office of Court Administration and the New York State Rent Regulations Services Unit are not eligible for the prescription drug benefit.

Benefits available only to you (the retiree):

Death Benefit
Audiology
Podiatry

II. PENSIONABLE PART-TIME RETIREE ELIGIBILITY REQUIREMENTS

In order to qualify for the Former Part-Time Employee Health and Security Plan Benefits package as a retiree, you must satisfy all of the following requirements:

1. You had to retire subsequent to July 31, 1992;
2. You had to be in a part time title covered by the DC37 welfare fund or in a title covered by contractual agreement at the time of retirement;
3. You had to qualify for Health and Security Plan Benefits for a full year prior to your retirement;
4. You had to have the minimum required years in the New York City Employees' Retirement System or a similar retirement system at the time of separation from the Employer;
5. You had to remain a primary beneficiary of the Employer's paid health insurance program or provide a copy of your waiver of Employer's paid health insurance; and
6. You must be receiving a pension.

If you meet all of the above requirements, the following benefits are available to you,(the retiree only).

Dental Benefit
Prescription Drug Benefit*
Vision Care Benefit including Supplemental Optical Benefit
Health and Pension Counseling
Second Surgical Consultation
Social Service Crisis Intervention (Personal Service Unit)
Municipal Employees Legal Services Benefit¹
Death Benefit
Audiology
Podiatry

*Former employees of the Office of Court Administration and the New York State Rent Regulations Services Unit are not eligible for the prescription drug benefit.

Please note that this benefit package is available to the retiree only, your spouse and dependents are not eligible for benefits. The spouse and dependent children of an eligible member can purchase coverage through COBRA for a period of 36 months, measured from the member's termination date as an active employee. Upon the completion of 36 months of COBRA coverage, the spouse can continue to obtain prescription drug coverage at a reasonable rate. The drug coverage will continue as long as the member is eligible for coverage and the premium payments are made in a timely manner.

¹ Local 375 Civil Service Technical Guild active employees and retirees are covered by the Local's Professional Employees Legal Services.

III. PENSIONABLE FORMER DEPT. OF EDUCATION HOURLY EMPLOYEE ELIGIBILITY REQUIREMENTS

In order to qualify for the Pensionable Former Department of Education Hourly Employee Health and Security Plan Benefits as a retiree, you must satisfy all of the following requirements:

1. You were a pensionable employee of the Department of Education in one of the titles listed below:
 - A. Film Inspection Assistant
 - B. School Aide
 - C. School Health Services Aide
 - D. School Lunch Helper
 - E. Senior School Lunch Helper
2. You had to retire subsequent to July 31, 1992;
3. You must be a member of the Dept. of Education Retirement System;
4. You had to have the minimum required years in the Dept. of Education Retirement System to qualify for a pension at the time of separation from the Dept. of Education;
5. You must be receiving a pension;
6. You had to remain a primary beneficiary of the Employer's paid health insurance program or provide a copy of your waiver of Employer's paid health insurance; and
7. You had to qualify for Health and Security Plan benefits for the school year prior to your retirement.

If you meet all of the above requirements, the following benefits will be available to you and your eligible dependents:

Dental Benefit
Prescription Drug Benefit
Vision Care Benefit including Supplemental Optical Benefit
Health and Pension Counseling
Second Surgical Consultation
Social Service Crisis Intervention (Personal Service Unit)
Survivor Benefit
Municipal Employees Legal Services Benefit

Benefits available only to you (the retiree):

Death Benefit
Audiology
Podiatry

IV. NON-PENSIONABLE FORMER DEPARTMENT OF EDUCATION HOURLY EMPLOYEE ELIGIBILITY REQUIREMENTS

In order to qualify for the Non-Pensionable Former Dept. of Education Hourly Employee Health and Security Plan Benefits package as a resignee, you must have been hired prior to 9/1/1995 and you must satisfy all of the following requirements:

1. You were a former employee of the Dept. of Education in one of the titles listed below:
 - A. Family Auxiliary: (Family Worker, Family Assistant, Family Associate, Parent Program Assistant)
 - B. Film Inspection Assistant
 - C. School Aide
 - D. School Health Services Aide
 - E. School Lunch Helper
 - F. Senior School Lunch Helper

2. You have worked a total of 10 continuous years in any of the above-mentioned titles;
3. You have completed at least 10 years in an hourly school lunch position and you were promoted to a monthly/annual school lunch position on or after Oct.1,1978;
4. If you resigned on or after October 1,1983, you must have attained the age of 60 prior to your resignation.¹
5. Effective October 1, 1983: If you reach your 60th birthday between the end of the school term (June) and the start of the next term (September), and you resign before the start of the new term, you will be considered on active status during the summer for the purpose of establishing eligibility.¹
6. Early resignation (Retirement) Due to Disability
If you become disabled between the ages of 55-60 and you are receiving a Service Compensation award or you have 10 years of continuous service (for other than Former Hourly Employee of the Dept. of Education and Family Auxiliary) and you meet the other eligibility requirements, you may apply for resignee benefits and become eligible for such benefits at age 60. You should have resigned between the ages of 55-60 on or after January 1, 1984.

If you meet all of the above requirements, the following benefits will be available to you and your eligible dependents:

- Dental Benefit
- Prescription Drug Benefit
- Vision Care Benefit including Supplemental Optical Benefit
- Health and Pension Counseling
- Second Surgical Consultation
- Social Service Crisis Intervention (Personal Service Unit)
- Survivor Benefit
- Municipal Employees Legal Services Benefit

Benefits available only to you (the resignee):

- Death Benefit
- Audiology
- Podiatry
- Health Insurance *****

*****If you meet the eligibility requirements and you are between the ages of 60 and 65, you may elect a health insurance program (GHI-Blue Cross, HIP-HMO or GHI-Med Team). This program is not for your spouse or dependents. The program terminates when you become eligible for Medicare.

V. PENSIONABLE FORMER SCHOOL CROSSING GUARDS ELIGIBILITY REQUIREMENTS

In order to qualify for the Pensionable Former School Crossing Guards Health and Security Plan Benefits package as a retiree, you must satisfy all of the following requirements:

1. You had to retire subsequent to July 31, 1992;
2. You must be a member of the Dept. of Education Retirement System;
3. You had to have the minimum required years in the Dept. of Education Retirement System (or combined years of service with NYCERS) to qualify for a pension at the time of your separation from the Police Department;
4. You must be receiving a pension;
5. You had to remain a primary beneficiary of the Employer's paid health insurance program or provide a copy of your waiver of Employer's paid health insurance; and
6. You had to qualify for Health and Security Plan Benefits for the school year prior to your retirement.

¹ Effective 9/30/1978, age requirement was 65.

If you meet all of the above requirements, the following benefits will be available to you and your eligible dependents:

- Dental Benefit
- Prescription Drug Benefit
- Vision Care Benefit including Supplemental Optical Benefit
- Health and Pension Counseling
- Second Surgical Consultation
- Social Service Crisis Intervention (Personal Service Unit)
- Survivor Benefit
- Municipal Employees Legal Services Benefit

Benefits available only to you (the retiree):

- Death Benefit
- Audiology
- Podiatry

VI. NON-PENSIONABLE FORMER SCHOOL CROSSING GUARD ELIGIBILITY REQUIREMENTS

In order to qualify for the Non-Pensionable Former School Crossing Guard Health and Security Plan Benefits as a resignee, you must have been hired prior to 9/1/1995 and you must satisfy all of the following requirements:

1. You have worked a total of 10 continuous years as a School Crossing Guard. If you were terminated in 1975 because of the dissolution of the School Crossing Guard Program and if you were reappointed by June 30, 1979, you will be considered as not having a break in service.
2. Your effective date of resignation is on or after January , 1984, and you were 60 or older at that time.
3. You had to be eligible for DC37 Health and Security Plan Benefits prior to resignation.
4. If you reach your 60th birthday in the months between the end of the school term (June) and the start of the next term (September), you will be considered on active status for the purpose of establishing eligibility.

If you meet all of the above requirements, the following benefits will be available to you and your eligible dependents:

- Dental Benefit (limited benefit, detailed in Dental benefit section)
- Prescription Drug Benefit
- Vision Care Benefit including Supplemental Optical Benefit
- Health and Pension Counseling
- Second Surgical Consultation
- Social Service Crisis Intervention (Personal Service Unit)
- Municipal Employees Legal Services Benefit (limited benefit, detailed in MELS benefit section)

Benefits available only to you (the resignee):

Health Insurance*****

*****If you meet the eligibility requirements and you are between the ages of 60 and 65, you may elect a health insurance program (GHI-Blue Cross, HIP-HMO, GHI-MedTeam). This program is not for your spouse or dependents. The program terminates when you become eligible for Medicare.

VII. RETIREE BENEFITS FOR FORMER FAMILY AUXILIARY EMPLOYEES WHO JOINED THE TEACHER'S RETIREMENT SYSTEM

1. The member must have a minimum of 10 years in the Teacher's Retirement System;
2. The member must be receiving a pension;
3. The member must qualify for Health Insurance coverage through the Dept. of Education (Note : the member must apply for this coverage at the time of retirement through their personnel office);
4. The member must contact the Health & Security Plan office and submit a copy of the member's Teacher's Retirement System pension stub, and a copy of the Retiree Health Benefits application. The Health & Security Plan will activate the member's eligibility for retiree benefits (subject to receiving contributions from the Dept. of Education on behalf of the member). It is important to note that an arrangement was made with the Dept. of Education to furnish the Plan with quarterly reports which will identify those Family Auxiliaries for whom contributions will be forthcoming.

If you meet all of the above requirements, the following benefits will be available to you and your eligible dependents:

Health and Security Plan Benefits available to you (the retiree) and your dependents:

- Dental Benefit
- Prescription Drug Benefit
- Vision Care Benefit including Supplemental Optical Benefit
- Health and Pension Counseling
- Second Surgical Consultation
- Social Service Crisis Intervention (Personal Service Unit)
- Survivor Benefit
- Municipal Employees Legal Services Benefit

Benefits available only to you (the retiree):

- Death Benefit
- Audiology
- Podiatry

Benefits for Former Employees, whether pensionable or non-pensionable, are not vested. As with the benefits provided to active employees, these benefits are funded through the ongoing contributions and monies received by the Plan from the employer. The Trustees reserve the right to amend, suspend or eliminate the benefits received by both pensionable and non-pensionable Former Employees and their beneficiaries at any time. Among the circumstances, which might cause the Trustees to take such action would be a cessation or reduction in the amount of contributions and monies being received from the employer on behalf of pensionable and non-pensionable Former Employees.

ENROLLMENT INFORMATION FOR ALL ELIGIBLE RETIREES AND RESIGNEES

In order to complete your retirement file, you will be required to provide certain documentation including a copy of your pension check stub and your health insurance form. You must also send a copy of your or your dependent's Medicare card to the Plan office when you or your dependent become eligible for Medicare Part A and Part B.

An enrollment card must be on file with the Health and Security Plan before you can obtain benefits.

- If you are a newly covered retiree whose welfare fund coverage was provided by a union other than the DC37 Health and Security Plan, you must attach copies of your marriage certificate or domestic partnership papers and birth certificate(s) of your eligible child(ren) to your enrollment records card.
- If you were enrolled in the Health & Security Plan as an actively working member and are now a retiree or resignee and you recently married or added a domestic partner or recently became a parent, then you must complete a "Change of Status Card" adding your new family members to your file. Be sure to add copies of the appropriate documents to the card before returning it to the Plan.
- If you are adding a spouse or domestic partner, be sure to include all spousal and domestic partner employment and insurance related information on the Change of Status Card.
- If the change in dependent status is due to a death, separation, divorce or dissolution of a domestic partnership, you must notify the Plan office of this, on a Change of Status Card, but documents are not necessary.
- If you are changing your status, please consider updating your beneficiary information by requesting a Change of Beneficiary Card from the Plan office.

In order to facilitate enrollment, it is necessary that all forms and documents received in this unit have the member's name, social security number or PID number on it. A member need only complete one enrollment card. All changes made after that card is on file, must be done on a Change of Status Card or Change of Beneficiary Card.

- All enrollment cards must be completed and signed by the member.
- Change of Beneficiary Cards must be signed and notarized.
- All change of status requests must have proper documentation attached (e.g., copy of birth certificate).

Most of these benefits also cover your legal spouse, domestic partner and children called "dependents" (except the Pensionable Former Part-Time Employee benefit package which is limited to member only coverage).

Your "legal" spouse is your wife or husband. Your children are all your natural or adopted children, no matter where they live (if you are responsible for their support), and the children of your spouse or domestic partner who are living with you.

Children are covered until the age of 19. If a child is a day student attending a vocational or academic school full-time, the child is covered until the age of 23. However, in order to determine eligibility for such dependents, the Plan must have a letter from the Registrar's Office on file indicating the dependent's current full-time status at the time these benefits are sought. To avoid an interruption in coverage, proof of schooling should be submitted twice yearly, at the beginning of the Spring and Fall semesters.

A totally disabled child is covered regardless of age, as long as the disability, physical or mental, began before the child reached age 19 or 23 if attending college full-time and the dependent is residing with the covered retiree/resignee. If the disabled dependent is at any point no longer totally disabled after his/her 19th or 23rd birthday, as the case may be, he/she will thereafter be ineligible as a covered dependent even if a subsequent disability is a recurrence of a prior condition. In order to establish eligibility for a totally disabled child, medical records and/or clinical evaluation(s) must be submitted to the Plan office. You must apply for coverage for a disabled dependent within 6 months of the member becoming eligible for Health and Security Plan benefits.

Married children are not covered; nor are children who regularly works more than 20 hours a week.

The Plan will comply with the terms of any Qualified Medical Child Support Order (QMCSO) as defined by the employer. A QMCSO may require the Plan to make coverage available to your child even though the child is not, for income tax purposes or Plan purposes, your legal dependent because of separation or divorce. In order to be a qualified order, the medical child support order must be issued by a court, clearly specify the alternate recipient, reasonably describe the type of coverage to be provided to such alternate recipient, and clearly state the period to which such order applies. A copy of the Plan's procedures for determining the qualified status of a medical child support order are on file at the Plan office.

MELS Legal Benefits are available to you and your dependents, except for the limitations described on page 38 and as listed previously in the eligibility requirements for each of the retiree/resignee groups. In addition, the special tax treatment of employer funded legal service plans ended on June 30, 1992, with the expiration of Section 120 of the Internal Revenue Code. Legal Services benefits are considered as gross income to each covered retiree/resignee and the value of this benefit will be added to your income and reflected on your W2. Because the Municipal Legal Service benefit (MELS) covers only retirees/resignees living in New York State within 50 miles of the Plan office, the MELS eligibility criteria have been amended so that those persons who are not eligible for the benefit will not be taxed.

The geographic area covered by MELS is limited to the following zip codes.

New York City

Brooklyn - 112

Bronx - 104

Queens - 110, 111, 113, 114

Manhattan - 100, 101, 102

Staten Island - 103

New York State

Nassau County - 110, 115, 116, 117, 118

Suffolk County - 117 except 11719, 11764, 11778, 11786, 11789 and 11792

Westchester County - 105, 106, 107, 108

Rockland County - 109

District Council 37 Health & Security Plan Trust

125 Barclay Street
New York, New York 10007
(212) 815-1234

Board of Trustees

Oliver Gray, Chair
125 Barclay St.
New York, NY 10007

Judith Arroyo
125 Barclay St.
New York, NY 10007

Carmen Charles
125 Barclay St.
New York, NY 10007

Lenora Gates
125 Barclay St.
New York, NY 10007

James Tucciarelli, Co-Chair
125 Barclay St.
New York, NY 10007

Carolyn Harper
125 Barclay St.
New York, NY 10007

Stuart Leibowitz
125 Barclay St.
New York, NY 10007

Maf Misbah Uddin
125 Barclay St.
New York, NY 10007

PART I
HEALTH AND SECURITY BENEFITS
Dental Benefit

The DC 37 Health & Security Plan's Dental Benefit is designed to help members and their families maintain healthy teeth and gums by lowering or removing the money barrier. This benefit covers a full range of services needed for dental health. Details regarding the limited dental benefit available under the Non-Pensionable Former School Crossing Guard package are available at the end of the Dental section.

There are three ways of using the dental benefit:

- a) The member and/or dependent(s) may use any licensed dentist who provides these services. You will be reimbursed by the Plan based on its fee schedule amount for covered services. You and your dependent(s) will be responsible for any difference between the Plan's fee schedule and the dentist's charges. Plan rules regarding restrictions, limitations, and annual dollar limit will also apply.
- b) The member and/or dependent(s) may use any dentist from the Plan's list of Participating Dentists. A participating dentist accepts the Plan's fee schedule amount as full payment for covered services. You will be responsible for any cost incurred, if you obtain treatment that is restricted or obtain treatment not covered on the fee schedule or the cost is above the annual dollar limit allowed. Contact the Plan's Inquiry Unit at 212-815-1531 or via our web site at www.dc37.net to obtain a listing of participating panel providers. Please note that if you use a participating panel provider in Georgia or Florida you are required to pay a fixed out of pocket co-payment for covered services.
- c) The member and/or dependent(s) may also obtain treatment at the DC 37 Dental Centers. The same Plan rules regarding: restrictions, limitations and/or annual dollar limit will also apply. Individuals who obtain treatment at the Centers will be required to comply with the policies and regulations established by the Centers for its patients. See section on Dental Center Policies.

A maximum of \$1,700 will be paid as benefits for each covered person in a calendar year based on the fee schedule. Benefits are paid after claim forms for completed services are submitted to the Plan and processed based on Plan rules and guidelines. Pre-Authorization requests are proposals for treatment. Services denied on a pre-authorization are not subject to the Plan's appeal process. If you use the

DC 37 Dental Centers, the scheduled value of the services provided will be credited toward the \$1,700 yearly maximum.¹ A copy of the Plan's fee schedule, along with a list of participating dentists can be obtained from the Plan office.

CLINICAL DENTAL EVALUATION

Members may be required, on occasion, to be clinically evaluated by a dentist selected by the Plan as part of the Plan's continuing effort to monitor the quality of care our members receive. An evaluation may be performed for work planned, but not yet done or for work completed and billed. A member's (or dependent's) failure to comply with such a request may result in a denial of benefits. Of course, the Plan will make every effort to schedule such an evaluation at a time convenient to the member or dependent, and reimburse him/her for carfare.

MANDATORY PRE-AUTHORIZATION

Pre-authorization is mandatory before beginning treatment for prosthetics (dentures and bridgework), crowns, extensive gum treatment, TMJ therapy, root canal therapy or orthodontics. This pre-authorization is for your benefit. You get a free second professional opinion to determine if the work is necessary. In addition, you will have advance notice of the extent of the work involved - dentally and financially. **YOU MUST SUBMIT FOR PRE-AUTHORIZATION FOR THE ABOVE LISTED SERVICES OR YOUR CLAIM FOR COMPLETED SERVICES WILL BE REJECTED.**

You may use the DC37 dental claim forms available at the Plan Office, or your dentist may submit universal claim forms. Your dentist will describe the proposed work, and attach x-rays to show that the work is necessary. You and your dentist should complete the form and send it to the Plan Office. The Plan Office reviews the Pre-Authorization plan, then notifies you and your dentist if the intended work is covered and for how much. **THIS ASSUMES, OF COURSE, THAT YOU ARE ELIGIBLE FOR BENEFITS WHEN THE WORK IS PERFORMED,** and takes into consideration the Plan's rules and regulations regarding yearly maximums and frequency limitations for certain procedures.

Information on how to obtain benefits is on page 35.

¹ As with all decisions regarding eligibility for and the amount of benefits payable under the Plan, these allowances and guidelines are subject to change, at any time and for any reason, by the Board of Trustees of the Plan, in its sole and absolute discretion. If you have any questions, contact the Plan office.

GUIDELINES OF THE PLAN'S DENTAL SERVICES.

The following is a list of the types of services covered by the Plan.

Regular Examinations and Cleaning: Once every six months, measured from the date of service, you (and eligible dependents) can have your teeth examined by a licensed dentist to check for cavities and other dental or oral problems. You can also have your teeth cleaned and scaled once every six months.

Diagnostic X-Rays: You can have your whole mouth x-rayed once every two (2) consecutive calendar years. There is a \$50 maximum x-ray benefit for the two years. This does not apply to x-rays necessary to diagnose a specific disease or injury or to determine progress in its treatment. Benefits will be available for any post operative x-rays (except in root canal therapy) whenever it is requested by the Plan to help in an evaluation. The amounts that will be paid for individual x-rays are listed in the Plan's Dental Fee Schedule.

Fluoride Treatments: Once every six months, measured from the date of service, your children (18 years of age and under) can receive fluoride treatments to help prevent tooth decay.

Emergency Treatment: You are covered for treatment to alleviate pain when a toothache occurs.

Fillings: To repair decayed teeth.

Extractions: And other oral surgery covered as required.

Crowns (caps), Bridgework & Dentures: Crowns, bridgework and dentures are not covered during the first year of employment unless it is replacing a tooth which was extracted while you were a covered individual. Bridgework, dentures and crowns will not be replaced before a five (5) year period has elapsed from the original date of placement. The five (5) year period shall always commence on the date the device(s), paid for by the Plan, was inserted. If it becomes necessary to extract the abutment tooth of a bridge during this five (5) year period, the Plan will only pay for the replacement of the tooth providing it can be added to the existing appliance (an abutment tooth is the tooth which supports the fixed or partial denture).

Root Canal Therapy: Payment for root canal therapy is once in a lifetime per tooth.

Periodontia: Gum treatments and necessary periodontic care. If you use the periodontal panel or receive periodontal care at the DC 37 Dental Centers, there is a \$10 per quadrant co-payment for periodontal surgery.

Orthodontics: Orthodontic services are available to eligible dependent children only. The Plan will pay up to \$1840 for this very important aid to dental health. This is how the benefit is applied; the Plan pays up to \$400 for diagnosis and the orthodontic appliance, then up to \$60 a month for adjustments. The lifetime maximum for the orthodontia benefit is \$1840. No orthodontic services are available under the Pensionable Part-Time Employee package and Non-Pensionable Former School Crossing Guards package.

All of the above treatments are covered only if they are done by or under the supervision of a licensed dentist.

In all circumstances, Plan rules regarding restrictions, limitations, and annual dollar limit will apply.

The Plan's current dental fee schedule is available by calling the Inquiry Unit's Form's number (212) 815-1531.

COVERAGE EXCLUSIONS

1. In general, any dental work begun before you become eligible for dental benefits will not be covered, even if completed after you become eligible. For example, if a root canal was opened before becoming eligible, the root canal therapy will not be covered even if done at a later date. If you have a tooth prepared for a crown before becoming eligible, the crown is not covered even if it is put on after eligibility is established.
2. Benefits are not payable for more than one examination and cleaning in any six consecutive months.
3. The Plan does not pay an additional fee for the completion of forms.
4. Benefits are not payable for a prophylaxis rendered the same day as a periodontal treatment.

5. Benefits for fluoride are not payable for persons over 18 years of age.
6. Fluoride treatments for persons under 18 years of age are not payable more than once every six months.
7. Occlusal adjustments are limited to one full mouth adjustment every five years.
8. No additional allowance will be provided to connect or disconnect units involved in fixed bridgework.
9. Benefits are not payable for temporary crowns unless necessitated by an accidental injury to natural teeth.
10. A temporary restoration (except when necessitated by accidental injury) is considered part of and is included in the allowance for the final restoration.
11. No additional benefits will be provided for post operative treatment.
12. Payment is limited to: a) two pins per tooth, b) \$55 filling benefit per tooth.
13. Benefits are not payable beyond a maximum of \$1700 per covered individual per calendar year.
14. Benefits are not payable for the following services to a covered individual: (i) an appliance, or modification of an appliance, for which an impression was made before the person became a covered individual, or (ii) a crown, bridge or gold restoration, for which a tooth was prepared before the person became a covered individual, or (iii) root canal therapy, for which the pulp chamber was opened before the person became a covered individual.
15. Benefits are not payable for a partial or full removable denture or fixed bridgework if it involves replacement of one or more natural teeth extracted prior to the employee being in a covered job title for a consecutive 12 month period, unless the denture or fixed bridgework also includes replacement of a natural tooth which (i) is extracted while the person is such a covered individual and (ii) was not an abutment to a partial denture or fixed bridge installed within the immediately preceding five years.
16. Benefits are not payable for a new partial or full removable denture or fixed bridgework, or a crown or gold restoration, if it involves the replacement of a denture, bridgework, crown or gold restoration which was inserted during the immediately preceding five years. The five (5) year period shall always commence on the date the device (s), paid for by the Plan, was inserted.
17. Benefits are payable for a precision denture up to the maximum scheduled benefit allowable for a cast or acrylic based partial denture with a gold or chrome lingual or palatal bar with two clasps. However, crowns inserted as abutments for precision or semi-precision attachment appliances and cast or acrylic based partial dentures are not covered except where necessitated by either periodontics or restorative reasons.
18. Adjustments to dentures and space maintainers are considered part of the allowance if made within four months of installation. The relining of an immediate denture will be considered after four months from the insertion date. An office reline will be limited to once every twelve (12) months. A laboratory reline will be limited to once every twenty-four (24) months.
19. Any service not listed in the Plan's fee schedule will be excluded except as follows: If a charge is incurred for a service not included in the schedule, in connection with the dental care of a specific covered condition, and if the schedule contains one or more services which, according to customary dental practices, are, in the Plan's opinion, appropriate for the dental care of that condition, then a charge for the least expensive of such services as are included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.
20. Expenses incurred after the termination of a person's coverage are not reimbursable except as applicable under the Extension of Benefits Provision as described in the section "Who is Eligible for these Benefits".
21. Charges in excess of the scheduled fee shown in the Plan's benefit schedule.
22. Charges for procedures rendered before a person becomes eligible for benefits.
23. A service not reasonably necessary, or not customarily performed, for the maintenance of the patient's health.
24. A service furnished a person for cosmetic purposes, unless necessitated as a result of an accidental injury sustained while the person was a covered individual.
25. Facing on crowns, or pontics, which are posterior to the first molar are considered cosmetic and are excluded in accordance with exclusion 24 above.
26. Any employment related disease or injury to the teeth, which is covered by any Workers' Compensation law, occupational disease law, or similar legislation.
27. A service or supply (i) furnished by or for the U.S. Government, (ii) furnished by or for any other government unless payment is legally required, or (iii) to the extent any benefit is provided by any law or government program under which the person is or could be covered.
28. Charges covered by another group dental insurance plan. See section regarding "Coordination of Benefits" for specifics.
29. Replacement of lost or stolen appliances.
30. Any dental service, which is not furnished by a licensed dentist, unless performed by a licensed

dental hygienist under the supervision of a dentist or is an x-ray ordered by a licensed dentist.

31. Services covered by any other Medical or Surgical benefit or insurance program.
32. Charges for oral hygiene instruction, dietary planning, etc.
33. Dental supplies, including, but not limited to, toothbrushes, toothpaste, mouthwash, water-piks, etc.
34. Payment for periodontal surgery is restricted to once every five years. Each quadrant will be considered individually.

Note: You have the right to a reduction or the limitation of exclusionary periods for preexisting conditions if you have creditable coverage from another plan. If you are denied coverage for a preexisting condition and can provide proof of previous coverage the Plan will consider reducing or eliminating the exclusion, as long as the new coverage starts within 62 days of the date the prior coverage ended.

The DC 37 Dental Centers are located at 115 Chambers Street in Manhattan and 186 Joralemon Street in Brooklyn.

If you use these Centers you will not incur any additional out of pocket expenses for covered

procedures and services within the total treatment plan cost, except for a \$10.00 co-payment for periodontal treatment per quadrant. The yearly maximum benefit is \$1,700 per calendar year, based on the Plan's fee schedule. In all circumstances, Plan rules regarding restrictions, limitations, and annual dollar limit will apply.

In addition, a list of dentists who have agreed to accept the fees listed in the allowable schedule as full payment for the described procedures and service is available. These dentists are called Participating Dentists. If you use a Participating Dentist, you will not incur any out of pocket costs for covered procedures and services except as noted regarding periodontia.

Of course, your own dentist may also accept these amounts. Check the fees and our schedules before having any work done.

The yearly maximum benefit is \$1,700 per calendar year, based on the Plan's fee schedule. In all circumstances, Plan rules regarding restrictions, limitations, and annual dollar limit will apply.

Dental Benefit As It Pertains To Non-Pensionable Former School Crossing Guards

The DC 37 Health & Security Plan’s Dental Benefit is designed to help members and their families maintain healthy teeth and gums by lowering or removing the money barrier. This benefit covers a full range of services needed for dental health-**WITH THE EXCEPTION OF ORTHODONTICS.**

The dental benefit will reimburse at 75%, on a procedure basis your treatment or that of your eligible dependent, based on the DC37 Dental Fee Schedule. You would be responsible for the balance of your dental bill which would be the remaining 25% of the total cost and any difference between the actual dentist charges and the scheduled amount.

The following example shows how benefit payments are calculated.

| Dental Procedure | Dentist’s Actual Charges | Schedule Amount | 75% of Schedule Amount | Member’s 25% of Schedule Amount |
|-------------------------|--------------------------|-----------------|------------------------|---------------------------------|
| Dental Procedure | 40.00 | 25.00 | 18.75 | 6.25 |
| X-Rays & BW | 75.00 | 40.00 | 30.00 | 10.00 |
| Amal (3) Perm (Filling) | 80.00 | 50.00 | 37.50 | 12.50 |
| | <u>195.00</u> | <u>115.00</u> | <u>86.25</u> | <u>28.75</u> |

There are three ways of using the dental benefit:

- a) The member and/or dependent(s) may use any licensed dentist who provides these services. You will be reimbursed by the Plan based on 75% of its fee schedule amount for covered services. You and your dependent(s) will be responsible for any difference between the Plan’s fee schedule and the dentist’s charges in addition to 25% of the fee schedule amount. Plan rules regarding restrictions, limitations, and annual dollar limit will also apply.
- b) The member and/or dependent(s) may use any dentist from the Plan’s list of Participating Dentists. If you use a participating Dentist, the cost to you should be 25% of your total bill for covered services. You will be responsible for any cost incurred, if you obtain treatment that is restricted or obtain treatment not covered on the fee schedule or the cost is above the annual dollar limit allowed. Contact the Plan’s Inquiry Unit at 212-815-1531 or via our web site at www.dc37.net to obtain a listing of participating panel providers. Please note that if you use a participating panel provider in Georgia or Florida you are required to pay a fixed out of pocket co-payment for covered services in addition to the 25% of the fee schedule amount.

- c) The member and/or dependent(s) may also obtain treatment at the DC 37 Dental Centers. If you elect to be treated there, the out-of-pocket cost to you for covered procedures will be 25% of your total treatment cost. The same Plan rules regarding: restrictions, limitations and/or annual dollar limit will also apply. Individuals who obtain treatment at the Centers will be required to comply with the policies and regulations established by the Centers for its patients. See section on Dental Center Policies.

A maximum of \$1,700 will be paid as benefits for each covered person in a calendar year based on the fee schedule. Benefits are paid after claim forms for completed services are submitted to the Plan and processed based on Plan rules and guidelines. Pre-Authorization requests are proposals for treatment. Services denied on a pre-authorization are not subject to the Plan’s appeal process. If you use the DC 37 Dental Centers, the scheduled value of the services provided will be credited toward the \$1,700 yearly maximum.¹ A copy of the Plan’s schedule of benefits, along with a list of participating dentists can be obtained from the Plan office.

¹ As with all decisions regarding eligibility for and the amount of benefits payable under the Plan, these allowances and guidelines are subject to change, at any time and for any reason, by the Board of Trustees of the Plan, in its sole and absolute discretion. If you have any questions, contact the Plan office.

JORALEMON DENTAL SERVICES, P.C.

DENTAL CENTER POLICIES

Manhattan Center
115 Chambers Street
New York, N.Y. 10007
(212) 766-4440

Brooklyn Center
186 Joralemon Street
Brooklyn, N.Y. 11201
(718) 852-1400

The following is a statement of the policies of the Dental Centers. This policy statement is distributed to each patient at his or her initial appointment. It is expected that each patient will sign this statement before dental treatment begins.

DC 37 Health & Security Plan Rules and Regulations limit your Dental Benefits to \$1,700 per year based on the Plan’s fee schedule. Expenses indicated on your Explanation of Benefits (EOB) Statement as “Balance Due” are the member’s responsibility, whether or not you were informed prior to treatment. To avoid problems, please discuss your treatment with your Dentist or Treatment Plan Coordinator.

When your first appointment is scheduled, you will be assigned to a general dentist. Due to the volume of patients seen at the Center, it is not feasible to have patients select their own dentist. The dentist will refer the patient to the hygienist. If necessary, specialty care will be provided for active patients of the Centers.

All visits are by appointment only. Emergency visits are also by appointment and are not treated on a walk-in basis. If you have an emergency, you must call the Center early in the day. The screening dentist will advise you how to proceed.

The Centers render limited treatment on a case by case basis to patients who have implants.

No-Shows – A patient will be considered a “no-show” if s(he) fails to appear for a scheduled appointment, or gives the Center less than 24 hours notice to cancel an appointment. If three (3) or more no-shows occur, we will ask you to seek dental treatment outside of the Center. If you are a no-show two (2) or more times for a Specialist appointment, we will also ask you to seek treatment outside of the Center.

Lateness – Patients are seen by appointment only and time is allocated based upon the procedure(s) to be completed. If a patient is late for his or her appointment, we may not have sufficient time to do the scheduled work. In these cases, we reserve the option to reschedule your appointment. Habitual lateness will be treated as a no-show.

Cancellations – A minimum of 24-hours notice is required for an appointment to be cancelled. Anything less than 24 hours notice will be considered a no-show.

Maintaining your status as an active patient requires your cooperation. The Center provides comprehensive general dentistry and recommends that patients return each year for a dental check up. If more than two years lapse, you will not be given an appointment until you again place your name on the waiting list. We do not co-treat patients who are in active dental treatment outside of the Center, except for orthodontics.

We offer these explanations of our policies to assist you. It is not possible for us to address each individual’s specific circumstances. You are encouraged to ask questions for further clarification.

My signature indicates that I have been informed of the policies at the Dental Center and received a copy of said policy.

Member/Patient’s Signature

Date

Vision Care Benefit

STANDARD BENEFIT

Once every two years, measured from your last date of service, eligible individuals may receive a Vision Benefit, which includes an eye examination, and if needed, eyeglass frames and eyeglass lenses. You may not need all three parts of the Vision Care Benefit. The examination may show that you do not need glasses, or that you need only new frames and not new lenses. If so, only the necessary services will comprise your complete Vision Care Benefit for the two-year period. Example: If you file a claim for an eye examination and single vision lenses obtained on July 1, 2007 you will be reimbursed \$15.00 for your Optical Expense claim. If you file a claim for an eye examination, single vision lenses and frames you will be reimbursed \$20.00. In both examples you will once again become eligible for Optical Benefits on or after July 1, 2009 (after two years have elapsed).

There are two ways of using your Optical Benefit: using a Voucher or getting Direct Reimbursement.

Using a Voucher - You can call or write to the Plan office and request a voucher. The Voucher is accepted by the participating optometrist, optician or the DC 37 Vision Center, as full payment for the examination and any necessary eyeglasses, as listed in the following schedule. Please note that if you use a participating panel provider in Florida you are required to pay a fixed out of pocket co-payment for covered services. **Contact Lenses are not available at the DC 37 Vision Center.**

You have to use the Voucher within 90 days of the date of issuance. If the Voucher is lost, destroyed or stolen, you must submit a notarized statement indicating that the Voucher was lost, destroyed or stolen. If an optical Voucher expires, you must return the expired Voucher to the Plan office and indicate if you wish to receive a new Voucher, or simply to void this one. Upon receipt of the expired Voucher, we will void it and correct your optical history file. We can then issue another Voucher whenever you ask. A listing of Participating Optical Providers is available at the Plan office.

Using Direct Reimbursement - you must fill out the Optical Benefit Reimbursement Form (obtainable from the Plan office) and return the completed form to the Plan for reimbursement. The Plan will reimburse you for what you spent for each procedure or item up to the amounts listed on the following schedule.¹

| | |
|--|---------|
| Eye Examination | \$ 6.00 |
| Single Vision Lenses (Standard lenses) | 9.00 |
| Bifocal Lenses (Standard lenses)..... | 16.00 |
| Trifocal Lenses (Standard lenses) | 20.00 |
| Progressive Lenses (Standard lenses)..... | 16.00 |
| Frame | 5.00 |
| Plastic Aspheric Single Vision Cataract Lenses | 40.00 |
| Plastic Aspheric Bifocal Cataract Lenses | 65.00 |
| Contact Lenses..... | 14.00 |
| Cataract Contact Lenses ² | 45.00 |

You will be reimbursed for each procedure or item according to the allowable fees listed in the fee schedule above. Please note that cataract contact lenses can only be obtained through the direct reimbursement method.

REMINDER

In order to maximize your optical benefit you must obtain and file for all three services—eye examination, lenses and frames—simultaneously, on the same claim form, whether using the Voucher or direct reimbursement method. The three parts of the benefit cannot be split between the two available methods, Voucher or direct reimbursement. You should be aware that partial usage of the benefit will be considered the same as full usage. That is to say, if you receive an examination only and you do not obtain lenses and frames, you cannot use the Standard Benefit for two years. The two-year period is measured from the date of the examination, if only an exam was obtained, or the date of payment, if lenses and frames were obtained.

SUPPLEMENTAL OPTICAL BENEFIT

You and your eligible dependents may use the DC 37 Vision Center operated by Hear & See Right, Inc. at 115 Chambers Street in Manhattan. In addition to using a Standard Optical Benefit (which is available once every two years) at the Vision Center, you and your eligible dependents can apply for the Supplemental Optical Benefit. This benefit is provided at the Vision Center only and is available once every 12 months, measured from the date that the Standard Benefit was last used. The benefit consists of an eye examination and a change of lenses, if prescribed by the Vision Center's optometrist. Appointments must be scheduled in advance at the Vision Center. Information on filing optical benefit claims is on page 35.

¹ As with all decisions regarding eligibility for and the amount of benefits payable under the Plan, these allowances are subject to change by the Board of Trustees of the Plan at any time and for any reason. If you have any questions contact the Plan office.

² If you are Medicare eligible, you must use Medicare as the primary (first) carrier when you submit a claim for cataract lenses. In addition, if you use the Vision Center for this service, a claim must be completed and submitted for processing to Medicare.

Prescription Drug Benefit

The Prescription Drug Benefit pays most of the cost of prescription drugs. A covered prescription drug is a drug approved by the Food and Drug Administration (“FDA”), used for the purpose and time period approved by the FDA and which cannot be purchased without a Physician’s or Dentist’s prescription (except prescription medications that have over the counter counterparts); or drugs which require compounding, except that such term shall include prescribed insulin or drugs that have not been specifically excluded. While allergens are not prescription drugs, they are covered under the Plan if the medication is purchased from an allergy testing lab or a Participating Pharmacy and is prescribed by your doctor.

Generic Based Prescription Drug Benefit

The Plan has a generic based Prescription Drug Program. This means that the Plan will only be responsible for paying covered prescription medication at the generic rate, except when there is no generic available and the brand name drug is the only drug available (sole source).

The Prescription drug benefit is available to the covered member and eligible dependents. The prescription drug benefit consists of a three tier co-payment program. The following co-payments are in effect as of July 1, 2006:

| DRUG | 30 days @ Retail Pharmacy | 90 days @ Retail 90 Rx Pharmacy | 90 days @ Voluntary Mail Order Pharmacy |
|---------------------|---------------------------------|--|--|
| Generic | \$5 | \$15 | \$10 |
| Preferred Brand | \$15 | \$45 | \$30 |
| Non-Preferred Brand | \$35 | \$105 | \$70 |

If you choose to obtain a brand name drug that has a generic equivalent, then you will be responsible for paying the difference in cost between the brand name drug and the generic drug in addition to the appropriate co-payment. In no case will you be charged more than the cost of the medication. If a generic equivalent is not available, instruct your physician to prescribe a preferred brand name medication.

It is important to note that the Food and Drug Administration requires that generic drugs must meet the same standards for purity, strength and safety as the brand name drug.

PICA

The Psychotropic, Injectable, Chemotherapy & Asthma (PICA) Program

As a result of a benefit bargaining agreement reached between the City of New York Office of Labor Relations and the Municipal Labor Committee of which DC 37 is a member, a program, known as PICA was effective July 1, 2001. This program made these four classes of drugs available to all employees, non-Medicare eligible retirees and their eligible dependents in a City sponsored health plan.

Medications in these four categories were provided through the PICA program only, except where otherwise covered under a City sponsored basic health plan.

Effective July 1, 2005, the City sponsored program continued to cover two classes of medication, Injectables and Chemotherapy. Psychotropic and Asthma medication coverage reverted to the Plan’s responsibility and are subject to Plan rules and co-payments.

DC 37 Health and Security Plan members covered by the program must use their City of New York PICA prescription card for injectable and chemotherapy medication. Questions about the PICA program should be directed to the telephone number on the back of the NYC PICA prescription card.

The Preferred Products List

Because of the escalating cost of the Prescription Drug Benefit, the Plan has instituted a Preferred Products List. The list identifies prescription drugs that can be used for virtually all illnesses and conditions and will meet the needs of all types of patients. The List was developed by a select group of physicians and pharmacists to ensure that all the drugs are therapeutically sound.

When there is no generic drug available, use a prescription that appears on the Preferred Products List. It will save money for you and the Plan.

Mail Order Program

The mail order program is a voluntary program designed for persons who have a long-term illness that requires maintenance type medication. You will save money because you get a 90 day supply of medication for the cost of two co-payments as opposed to a 90 day supply at a Retail 90 Rx pharmacy for three co-payments. Please allow 14 days for delivery from the date you mail in the original prescription. Be sure to enclose a check or money order which reflects the cost and/or the co-payments associated with the prescriptions you

send to the Mail Service Program. For additional information about the mail order program you can access the DC 37 website at www.dc37.net or contact the Plan's Inquiry Unit at 212-815-1234.

Annual Limit

The Annual limit for the prescription drug benefit is \$100,000 per cardholder, per calendar year. The cardholder includes the total prescription utilization of the member and all eligible dependents. The Plan's annual limit consists of Plan approved medications and is subject to all Plan rules and guidelines.

Rx Instep (Step Therapy Program)

The Plan has instituted the mandatory Rx Instep program especially for people who take prescription drugs to treat certain ongoing medical conditions with safety, cost and, most importantly, your health in mind.

It allows you and your family to receive the affordable treatment you need and helps the Plan contain the rising cost of prescription drug coverage.

- The program starts with generic drugs in the "first step". The generics covered by the Plan have been proven to be effective in treating many medical conditions. You will have the lowest co-payment for a first step generic drug.
- More costly brand name drugs are usually covered in the second step, even though generics have been proven to be effective in treating many medical conditions. These brand name drugs will have higher co-payments.

The drug categories in the Rx Instep program include high blood pressure, dermatitis and eczema, attention deficit hyperactivity disorder, asthma and allergy, depression, rheumatoid arthritis, diabetes³, pain and arthritis medication and ulcer and gastro-esophageal reflux disease medication.

If your doctor is prescribing a medication for an Rx Instep therapy condition for the first time, ask your doctor to prescribe a Step One medication. The Rx Instep program's medication list is available at the Plan's website, www.dc37.net or from the Plan office.

If the initial treatment with a Step One drug does not work well, the patient can be given a more costly Step Two drug. You will not need an approval to fill the new prescription at the pharmacy because we will have a record of the use of the Step One drug.

If you are being prescribed medication for an Rx Instep therapy condition for the first time, and your doctor did not prescribe a Step One drug, your

pharmacist will receive a message indicating that our Plan has a Step Therapy program. The pharmacist will generally contact the physician to request a new prescription for a step one drug. If a physician is unavailable, the member or patient will be responsible for obtaining the new prescription. If you choose to get your written prescription filled as is, you will pay the full cost for it, and the medication will not be covered by the Plan.

Please note: If you were prescribed a Step Two medication in the past and have not filled a prescription for it in 120 days or longer, you will not be able to re-start that medication without first trying a Step One drug.

How To Use The Prescription Drug Card

The most effective way of using your Prescription Drug benefit for short-term medication is with the prescription drug card issued by the Plan. You take the card and your prescription, which must be written on your Physician's prescription pad, to a participating pharmacy. When getting medication from your neighborhood participating pharmacy, you can obtain a 30 day supply or 90 day supply based on your written prescription for the appropriate Plan co-payment. In the event that you did not receive a valid prescription drug card, or if your card has been stolen, lost or destroyed, you must notify the Plan office by calling the Inquiry Unit at 212-815-1234.

How To Use The Reimbursement Method

In case you do not have your prescription drug card with you, or if you do not go to a participating pharmacy, you must then utilize the Direct Reimbursement Method to obtain your prescription drugs. You must complete the Prescription Drug Benefit Reimbursement form available at the Plan office. You must send the form along with the prescription receipt to the Plan's Prescription Drug Benefit Administrator in order to be reimbursed. Your reimbursement amount is based on the participating pharmacy's contracted rate minus your co-payment and will be subject to Plan rules and restrictions. **If you obtained a brand name drug that had a generic equivalent, then you will be responsible for paying the difference in cost between the brand name drug and the generic drug in addition to the appropriate co-payment.** Reimbursement is based on a specific fee schedule, minus the appropriate co payment, regardless of what the pharmacist's charges are. The same fee schedule is used to reimburse a participating pharmacy when a member uses his/her prescription drug card.

³ See Important Note regarding coverage

Medicare Eligible Retirees/Resignees and the DC 37 Prescription Benefit

Actuaries for the Plan, using guidelines established by the Centers for Medicare and Medicaid Services, have determined that your prescription drug coverage with the Plan is, for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage.

Because your existing coverage is at least as good as or better than standard Medicare prescription drug coverage, you can keep this coverage and choose not to enroll in Medicare Part D coverage.

Should you no longer be eligible for the Plan's prescription drug coverage and choose to elect a Medicare Drug Plan you may not be subject to late enrollment penalties because your current Health & Security Plan benefit is considered creditable coverage. A copy of the Notice of Creditable Coverage is available on the Plan's website or by calling the Inquiry Unit at 212-815-1234.

If you are a retiree and do decide to enroll in an independent Medicare prescription drug plan or receive a prescription drug benefit through your enrollment in a Medicare Advantage Plan (doctor and hospital coverage) such as HIP/VIP or Secure Horizon/Oxford, your DC 37 Health & Security Plan prescription drug benefit will be affected. Please note that enrollment in a health plan outside of the City of New York's Employee Benefits Program may also affect your eligibility for Medicare Part B reimbursement.

You will receive your prescription drug benefits through that program first and will be responsible to pay any applicable premiums, deductibles or co-payments for that plan. These costs are not reimbursable by the DC 37 Health & Security Plan's prescription drug benefit.

Your DC 37 Health & Security Plan prescription drug benefit will not be available to you except for prescription drugs that are not covered by your Medicare Advantage Plan's formulary. In these cases, you must contact the Plan office and your DC 37 Health & Security Plan's prescription drug benefit will be reinstated for the dispensing of a Plan covered medication only, subject to Plan rules. Once you have reached your Plan's coverage gap or annual prescription drug limit, you will need to provide an Explanation of Benefits statement (EOB) from your plan indicating that you have met that plan's annual limit. This statement must be submitted to the DC 37 Health & Security Plan's Drug Unit.

The Drug Unit will then reinstate your DC 37

prescription drug benefit and you will be able to use your DC 37 prescription card for medications covered by our Plan at our co-payment schedule and subject to Plan rules. The DC 37 Health and Security Plan's prescription drug benefit cannot be re-instated without an Explanation of Benefit (EOB) statement from either your Medicare Drug Plan or your Medicare Advantage Health Insurance Plan.

This EOB statement must be sent to:
DC 37 Health & Security Plan, Drug Unit Room 813,
125 Barclay Street, New York, New York 10007-2179

COVERAGE FOR CERTAIN PRESCRIPTION DRUGS

The Prescription Drug Benefit normally provides coverage for prescription medication when used only for purposes approved by the FDA. However, effective January 1, 1991, the Board of Trustees extended coverage of prescription drugs for unlabelled cancer therapy under the following conditions:

Before cancer drug claims can be considered for payment, all three conditions must be met:

1. Medical records must be provided to the Plan by the treating physician;
2. Submission of proof that your basic health insurance carrier (i.e. GHI, HIP, Blue Cross, etc.) rejected the prescription drug claims for payment;
3. The patient's treating physician must demonstrate to the Plan that the medication being prescribed has been recognized by experts in the field as being effective. Recognition is shown by the presentation or reference to articles that have appeared in certain established medical publications.

It must be noted that, for cancer drug claims, the Prescription Drug Benefit will pay 50% of the Plan's allowance of the drug up to a lifetime maximum of \$5,000, using the direct reimbursement method only. Please send your treating physician's records; basic health insurance carrier rejection; and medical authority documentation to the:

DC 37 Health & Security Plan
125 Barclay Street
New York, NY 10007
Attention: Prescription Drug Unit

For additional information on filing Prescription Drug Claims see page 35.

IMPORTANT NOTE

1. For all active members, non-Medicare eligible retirees, and dependents enrolled in the City of New York's Health Benefits Program, diabetes medication is provided by the various health plans as part of the basic benefit package.
2. For all active members, non-Medicare eligible retirees, and dependents enrolled in the City of New York's Health Benefits Program, coverage for the following categories of medication: injectables and chemotherapy is provided by the PICA program.
3. All active and retired members of the Triborough Bridge and Tunnel Authority receive coverage for diabetes medication, injectables and chemotherapy through the DC37 Health & Security Plan.
4. Active employees and retirees of the Office of Court Administration and the State Rent Regulations Services Unit are not covered for prescription drug benefits through the DC 37 Health & Security Plan. Prescription drug coverage is provided through the New York State Health Insurance Program (NYSHIP).

EXCLUSIONS/LIMITATIONS:

The Prescription Drug Benefit will not cover the cost of:

- a. drugs prescribed for a patient confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar in-patient care facility, or drugs prescribed for a member or eligible dependent residing in an assisted living facility where medical, custodial or skilled nursing care is provided;
- b. drugs prescribed for any condition covered by Workers' Compensation, No Fault Automobile Insurance, or in any situation where third party medical insurance is available;
- c. chemotherapy obtained by a non-Medicare eligible member and/or eligible dependent; administered on an out-patient basis in a hospital; or administered in a doctor's office;
- d. vitamins, foods and diet supplements that may be purchased with or without a prescription;
- e. drugs supplied by a treating physician;
- f. investigational or experimental drugs;
- g. over-the counter drugs (drugs purchased without a prescription);
- h. prescription medications that have over the counter counterparts;
- i. appliances and all companion implements (devices) including syringes and needles for the administration of prescription drugs;
- j. drugs prescribed for cosmetic purposes;
- k. prescription drugs used for Intravenous Drug Therapy, which is infused in the home; and any

charge for the administration of home infusion of the drug;

- l. immunization agents and biological sera;
- m. refills of medication covered by the benefit described in this section in excess of five (5) 30-day refills in any six (6) month period;
- n. refills of maintenance drugs covered by the benefit described in this section in excess of three (3) 90 day supplies in any twelve (12) month period filled at the Plan's mail order program or a Retail 90 Pharmacy;
- o. diabetes medication for active members and non-Medicare eligible retirees and eligible dependents except as noted;
- p. chemotherapy and related medication for active members, non-Medicare eligible retirees and eligible dependents enrolled in the City of New York's Health Benefits program except as noted;
- q. injectable medication for active members, non-Medicare eligible retirees and eligible dependents enrolled in the City of New York's Health Benefits program except as noted;
- r. any medication for active employees and retirees of the Office of Court Administration and the State Rent Regulations Services Unit enrolled in the New York State Health Insurance Program.

The Prescription Drug Benefit will limit the coverage and cost of:

1. drugs used in amounts or quantities which exceed FDA approved guidelines, e.g., pergonal (fertility) no more than two (2) vials per day for twelve (12) days per cycle; and Proton Pump Inhibitors (PPIs) for longer than three (3) months;
2. FDA approved fertility medication, up to 12 treatments per lifetime;
3. coverage for the class of prescription drugs used to treat male sexual dysfunction will require pre-approval by the Plan, must be dispensed through our mail service program and will have a 50% co-payment and an annual cap of \$500.00;
4. coverage for the class of prescription drugs used to treat obesity will require pre-approval by the Plan and will have a 50% co-payment and an annual cap of \$500.00;
5. prescription drugs, if a health insurance carrier provides for prescription drug coverage, then that carrier is Primary for prescription drugs. Should there be an out-of-pocket expense after the basic health insurance carrier processes drug related claims, the Plan will consider Coordinating Benefits;
6. prescription drugs for a retiree, spouse or dependent if covered through enrollment in a Medicare Part D Drug Plan. The Medicare Part D Drug Plan will be considered Primary and the Plan will provide benefits after meeting the Med D Plan annual limit or coverage gap.

Members are reminded that when the spouse has separate prescription drug coverage (whether through the spouses' employment or other sources such as Veterans Administration Benefits, Workers' Compensation, Medicaid, Medicare, No Fault Insurance, etc.), the Plan deems this coverage to be the primary coverage for the spouse and the spouse must use his/her own coverage.

The Plan has increased costs due to improper use and/or abuse of the Prescription Drug Card. Members who, through carelessness or negligence, allow their Drug Card to fall into the

hands of unauthorized persons whether known to them or not will be held responsible for the misuse of the card that was entrusted to the member for his/her use and/ or for the use of his/her eligible dependents. Such unauthorized or improper use can also result in the suspension of all your DC 37 Health & Security Plan benefits.

Second Surgical Consultation

Much surgery is elective, that is, the operation is not required by a medical emergency. When to have the operation, or whether to have it at all, is a matter of opinion. Recent studies have shown that many elective operations are done without real need. For example, some studies have shown that as many as one out of every three hysterectomies done in recent years should not have been done at all.

This is also true for significant percentages of appendectomies, gall bladder operations, podiatric surgery, and other serious surgery. Prior to the surgery, you should discuss the operation with the surgeon and ask questions about what it entails, the risks and the fees involved.

Moreover, every operation involves risk of permanent disability or even death. No one should undergo surgery unless there is a sound life-saving or life-improving reason for taking this risk. That's why the Second Surgical Consultation Benefit was set up. It provides that if a physician recommends that you or a dependent should have surgery, you can get a second opinion from a highly trained specialist. This specialist will examine you and your records and tell you whether he/she agrees that the operation should be performed.

There is no cost for this Second Consultation; it is fully covered by this benefit. You do not have to accept the second opinion. The choice of whether to have an operation is yours.

THIS BENEFIT IS AVAILABLE TO MEMBERS REGARDLESS OF THE BASIC HEALTH INSURANCE OPTION ELECTED. YOU TOO MAY NOW HAVE THE BENEFIT OF A FREE SECOND OPINION PRIOR TO ELECTIVE SURGERY.

THE SECOND SURGICAL OPINION MUST BE OBTAINED THROUGH THE DC 37 HEALTH & SECURITY PLAN SECOND SURGICAL CONSULTATION UNIT OR THROUGH NYC HEALTHLINE

For information on how to get a Second Surgical Consultation, see page 35.

Death Benefit

When a retiree/resignee covered by the Plan dies, a Death Benefit of \$1,000 will be paid to his/her designated beneficiary(ies).

A member has the exclusive right to designate beneficiaries or change any designation of beneficiaries without the consent of the beneficiaries. The designation and/or change of beneficiary must be made upon forms specifically provided by the Plan for that purpose.

The designation or change of beneficiary takes effect immediately upon receipt of the appropriate form by the Plan and shall operate as a revocation of any previous designation. The divorce of a member shall serve to revoke any prior designation of the ex-spouse as a beneficiary unless the member indicates otherwise.

If a member names more than one beneficiary, then the designated beneficiaries shall share the death benefit equally unless the designation indicates a different allocation. If a designated beneficiary predeceases the member, then that beneficiary's share shall be divided among the remaining beneficiaries.

If a designated beneficiary is a minor, the Plan, at the sole discretion of the Trustees, may direct that the benefit be paid in either monthly installments to the parents of the beneficiary or in one lump sum payment to the legal guardians of such minor.

If a member is not survived by any beneficiaries, or has failed to name any beneficiaries, then the benefit will be paid in accordance with the Plan Document.

If the Trustees, in their sole and absolute discretion, determine that the deceased member's estate has insufficient assets with which to pay for the member's funeral, then the Trustees will direct that an appropriate portion of the Death Benefit shall be used to pay for the member's funeral expenses.

All members are reminded that beneficiary designations are treated as confidential information, which will not be disclosed by the Plan unless required to do so by law.

***The Death Benefit is not available to Non-Pensionable Former School Crossing Guards.**

Podiatry Benefit

Minor abnormalities in foot structures and/or ill-fitting shoes, can result in corns, calluses, bunions, etc. Although many of us experience these ailments, we often don't seek the care of a podiatrist because of the expense.

The Podiatry Benefit operated by Podiatry Options, P.C. is available only to you, the member at 115 Chambers Street, New York, New York; and 186 Joralemon Street, Brooklyn, New York. If you require podiatric care, you can utilize medical facilities and be treated by podiatrists who are committed to providing quality foot care.

The Podiatry Benefit consists of the following treatments:

1. podiatry examination including x-rays for diagnostic purposes;
2. routine foot care including removal of corns, calluses, warts and ingrown toenails;
3. orthopedic care of structural problems including casting, strapping and the fitting of orthotics. The laboratory fees associated with orthotics fabrication and adjustments are not covered;
4. general podiatric medical care including the treatment of infections, dermatitis, and inflammatory disorders. Injections may be administered if needed.

BENEFIT LIMITATIONS:

Surgical care such as bunionectomies, and hammertoe corrections are examples of procedures not covered by the Podiatry Benefit, but become the responsibility of the member and his/her primary health insurance carrier.

THE PODIATRIST WILL DETERMINE THE FREQUENCY OF VISITS. HOWEVER, NO MORE THAN 6 VISITS MAY BE SCHEDULED PER YEAR.

The Podiatry Centers are located at:

DC 37 Health Center

186 Joralemon Street
Brooklyn, New York 11201
Phone: (718) 625-2544

DC 37 Health Center

115 Chambers Street
New York, New York 10007
Phone: (212) 766-4455

Should you choose to use our facilities, an appointment is required.

IF YOUR BASIC HEALTH INSURANCE COVERAGE PROVIDES REIMBURSEMENT FOR A PODIATRY EXAMINATION AND/OR TREATMENT YOU WILL BE REQUIRED TO SIGN AN AUTHORIZATION FORM ALLOWING THE PODIATRY OPTIONS, P.C. TO FILE A CLAIM WITH YOUR INSURANCE CARRIER.

***The Podiatry benefit is not available to Non Pensionable Former School Crossing Guards.**

Audiology Benefit

The Audiology Benefit, which is operated by Hear & See Right, Inc., is provided in response to the many members who suffer hearing loss problems and don't have ready access to affordable quality care.

THIS BENEFIT IS AVAILABLE ONLY TO YOU THE MEMBER AND IS PROVIDED EXCLUSIVELY AT THE AUDIOLOGY CENTER LOCATED AT 115 CHAMBERS STREET, NEW YORK, NEW YORK, 10007 (212-791-2126).

Eligible members can use the above facility staffed by audiologists who are committed to providing quality audiological service.

The audiology benefit includes a comprehensive audiological evaluation, hearing aid evaluation and dispensing of a hearing aid if necessary.

If the comprehensive evaluation confirms a hearing deficiency, the member will be given a report, which should be taken to an Ear, Nose and Throat specialist. The Ear, Nose and Throat specialist will confirm that there is no medical conflict to the use of hearing aids, or will indicate the need for further medical care. The member must apply directly to his/her basic health insurance carrier for reimbursement of the specialist fee. **THIS FEE IS NOT COVERED BY THE AUDIOLOGY BENEFIT.**

Members who have coverage through an HMO must follow the procedures established by their carrier for seeing a specialist.

The findings of the Ear, Nose and Throat specialist are reviewed by the Center's Audiologist who then determines the proper course of treatment.

If deemed necessary by the Center's audiologist, the benefit will provide a maximum of one hearing aid within a three year period at no cost to the member. **If an additional hearing aid is required, the Center will provide it, but the member will have to pay for it at invoice cost.** The audiologist will adjust the hearing aid to insure that it is functioning properly to meet the needs of the member, and will assist the member during the initial adjustment period.

SERVICES NOT PROVIDED BY THE AUDIOLOGY BENEFIT:

1. Batteries will be provided with a hearing aid, but all future battery replacement will be the responsibility of the member.
2. Hearing Aid repairs (except those under the manufacturer's warranty) are not covered. The cost of repairs will be the responsibility of the member.
3. The cost associated with rehabilitation therapy needed to acclimate the user to the hearing aid will be the responsibility of the member.
4. The Plan will not service or honor claims for hearing aids obtained outside of the Audiology Center.
5. The benefit does not cover assistive listening devices.

If you are experiencing hearing problems, call the Audiology Center at (212) 791-2126 and make an appointment for a screening.

The Audiology Center is located at:
The DC 37 Health Center
115 Chambers Street
New York, N.Y. 10007

IF YOUR BASIC HEALTH INSURANCE COVERAGE PROVIDES REIMBURSEMENT FOR AN AUDIOLOGY BENEFIT, YOU WILL BE REQUIRED TO SIGN AN AUTHORIZATION FORM ALLOWING, HEAR & SEE RIGHT, INC., TO FILE A CLAIM WITH YOUR INSURANCE CARRIER.

***The Audiology benefit is not available to Non Pensionable Former School Crossing Guards.**

Personal Service Unit

Everyone has problems from time to time, and it's all right to seek help for them. Personal and family concerns, alcoholism and drug abuse, financial hardships, physical illness, difficulties with children are concerns that can cause a crisis that may require assistance.

To help you deal with crises or problems like these, the Plan has set up a special unit - the Personal Service Unit. The unit's counselors (professionally trained New York State licensed Social Workers) may be able to help you directly with short-term counseling; provide you with information about private or public social services to which you may be entitled; or refer you to the proper community agency to resolve the difficulties that you have been experiencing. **THIS IS A CONFIDENTIAL SERVICE.**

Remember, you don't have to wait until a problem becomes a crisis to call a counselor at the Personal Service Unit. Call if you have a question, or would like to have some assistance to prevent a problem from developing, either for yourself or other family members.

A. WHEN DO YOU NEED PSU?

1. Job Jeopardy:

Problems at work can result in disciplinary action. If you have received an oral or written warning, were brought up on charges, or are scheduled for a hearing, you or your representative should contact PSU. It is to your advantage to contact PSU at the earliest signs of trouble. If you are in job jeopardy, you have a unique opportunity to learn more about your problems and how to deal with them.

2. Personal and Family Problems:

Personal or family difficulties can lead not only to problems at work but to stress and a deterioration of physical and mental health. The Personal Service Unit can help you to better understand and manage such problems.

Other problems that the Personal Service Unit can help you with include:

- alcoholism
- anxiety
- birth of a child
- career issues
- depression
- domestic violence
- drug abuse
- major life changes
- mental illness
- parenting/single parenting/grandparenting
- prolonged illness of self or family member

- relationship problems
- stress

WHAT ARE THE SERVICES OFFERED?

1. Referrals:

The PSU staff will assist you and your family in obtaining services for mental health needs, family problems, health care needs and social services.

2. Community Resource Information:

The PSU staff will provide a list of resources available in the community for members and their dependents who need information only.

3. Individual Counseling:

The PSU staff will provide short-term counseling for emotional and family problems, alcoholism and drug abuse, stress, or other problems of a personal nature.

4. Group Counseling:

The PSU staff will provide small, informal group counseling for members with similar needs. PSU develops group programs in response to members' needs. Refer to the union newspaper for announcements of pending groups or call PSU for information.

5. Workshops and Conferences:

The PSU staff periodically provides participatory workshops and conferences such as:

- Pre-Retirement Planning Workshop.
- Stress Management Workshop.

6. Outreach Program:

The PSU staff together with a volunteer program of retirees, will assist:

- Pre-retirees to prepare for retirement.
- Retirees to deal with their change of status.
- Members on short-term disability in need of assistance.
- Members at risk of becoming disabled.

7. Pre-Certification of Mental Health, Alcoholism and Substance Abuse Benefits;

The PSU staff can pre-certify the utilization of GHI benefits for Mental Health, Alcoholism and Substance Abuse Treatment and arrange referrals for both in-patient and out-patient treatment. PSU staff can also negotiate the pre-certification of Mental Health, Alcoholism and Substance Abuse treatment for other Health insurance coverage.

HOW TO CONTACT PSU SCREENING:

Call the Personal Service Unit at: (212) 815-1260 Monday - Friday 9:00 a.m. - 1:00 p.m. If they are

busy providing services to other Union members, their telephones will be answered by an answering machine which will advise the caller that all the lines are busy. The member may have to call a number of times before getting a social worker due to the large volume of calls coming into the unit.

You may also contact the PSU by going there in person Monday – Friday 9:00 a.m. - 12:00 p.m.

WHAT TO EXPECT:

The member should be prepared to give a brief description of his/her problem, letting the social worker know who referred him/her to the Personal Service Unit and if the problem is job related. The social worker will then ask the member a number of questions relating to his/her job, family and income. This information is for purposes of planning services

for the membership. Please understand that the Plan may not cover certain services that are referred to you by the Personal Services Unit.

ALL CONTACT WITH THE PERSONAL SERVICE UNIT IS CONFIDENTIAL AND NO INFORMATION WILL BE SHARED WITH ANYONE OUTSIDE THE OFFICE UNLESS WRITTEN PERMISSION IS GIVEN TO DO SO.

Health and Pension Services Unit

The Health and Pension Services Unit assists members who have questions about City of New York health insurance and pension plans.

Health Insurance

The Unit will assist members in resolving problems arising from the submission of health insurance claims, rejection of claims, discrepancies in reimbursement, incorrect deductions, or termination of coverage.

The Unit will explain the benefits available under the City's health insurance plans, coverage available upon retirement and Medicare. If a member or dependent loses City coverage, the Unit will give assistance in obtaining continued coverage through COBRA.

Pension

The Unit answers questions relating to the benefits available under the various pension plans.

Another service provided by the Unit is pension counseling. Counselors are available, by appointment, to explain and estimate members' pension amounts, discuss pension options including survivor benefits, and to provide an overview of how to retire and benefits upon retirement. It is advisable for the member to make an appointment within six months of the planned retirement date; however, the Unit assists walk-ins when necessary.

In addition, the Unit advises members about disability pensions, including eligibility requirements and the steps necessary to protect the member from losing pension benefits. If a disability pension is denied by the City, the Unit also represents the member during the appeals process.

You can visit or write the Health and Pension Services Unit at 125 Barclay Street, New York, NY, Room 314, or call the Unit at (212) 815-1200.

Survivor Benefit

Upon the death of a covered retiree, the spouse and eligible dependents can continue to utilize the Plan benefits available to the covered dependents for a period of twelve months measured from the retiree's date of death.

In order to qualify for Plan benefits as a survivor, the surviving spouse and eligible dependents must have been eligible and enrolled for benefits under the retiree's plan at the date of death. The deceased retiree must have been eligible for Plan benefits at the date of death, and that benefit package must

have included a death benefit. The Survivor benefit is not available under the Non Pensionable Former School Crossing Guards package.

COBRA (the Consolidated Omnibus Budget Reconciliation Act) provides a surviving spouse and eligible dependents with the opportunity to continue these benefits by purchasing them for up to an additional two years.

COBRA Benefit

The Consolidated Omnibus Budget Reconciliation Act, also known as COBRA, was enacted April 7, 1986. This law requires that, the City and union welfare funds offer employees and their families the opportunity for a temporary extension of group health and welfare fund coverage (called “continuation coverage”) at 102% of the group rates, in certain instances where benefits under either City basic or the applicable welfare fund would be reduced or terminated.

Under the COBRA law, members have the right to purchase continuation coverage of health insurance (hospital and medical) and welfare fund benefits. To continue basic Health Insurance under the COBRA law members should contact their personnel office.

The Welfare Fund benefits available are:

Dental, Vision Care, Podiatry, Audiology, Supplemental Surgical and Prescription Drug (optional).

INITIAL COBRA NOTICE

Continuation Coverage Rights under COBRA

You are receiving this notice because you are covered under the Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances in the event that you or your family members lose your coverage. The right to elect COBRA was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).

This notice generally explains continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your continuation coverage rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should get a copy of the Plan document from the Plan Administrator.

COBRA continuation coverage for the plan is administered by the DC 37 Health and Security Plan (referred to in this section as the “COBRA Administrator”).

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. COBRA continuation coverage is offered to each

person who is a “qualified beneficiary.” A qualified beneficiary generally is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, their spouses and their dependent children may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

In order to continue these Welfare Fund Benefits, there must be a qualifying event as listed.

If you are an employee, you will become a qualified beneficiary if you will lose coverage under the Plan because one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse; or
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both.)

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent “employee” dies;
- The parent “employee’s” hours of employment are reduced;
- The parent “employee’s” employment ends for any reason other than gross misconduct;
- The parents become divorced or legally separated;
- The parent “employee” becomes enrolled in Medicare (Part A, Part B, or both); or
- The child stops being eligible for coverage under the plan as a “dependent child.”

Children who are born to or placed for adoption with a covered employee during the period of the employee’s continuation coverage also are qualified beneficiaries entitled to COBRA continuation

coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed with regard to your employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, then the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries if the bankruptcy results in the loss of their health coverage under the Plan. If this occurs, you should contact the Plan office concerning your rights.

Notice of COBRA Qualifying Event.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred.

Your employer has the responsibility to notify the COBRA Administrator if the qualifying event is the end of employment or reduction in hours of employment, death of the employee, or enrollment in Medicare (Part A, Part B, or both) or commencement of a bankruptcy proceeding with respect to the employer, within 30 days following the date coverage under the Plan ends due to the occurrence of any of these events.

For all other qualifying events (i.e., divorce or legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child), it is the responsibility of the covered employee or family member to notify the COBRA Administrator within 60 days after the qualifying event occurs. The notice must be in writing and must be sent to COBRA Administrator at: DC 37 Health & Security Plan Trust at 125 Barclay St. New York, New York 10007 Attn: Accounting Dept. 3rd floor. The notice must identify the qualifying event, the date on which it occurred and the names of the covered individuals whose coverage under the Plan will be lost due to the event. The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event. Once the COBRA Administrator is notified that a qualifying event has occurred, COBRA continuation

coverage will be offered to each of the qualified beneficiaries. Qualified beneficiaries have 60 days from the later of (i) the date of the loss of coverage because of the qualifying event, or (ii) the date of the notice of the right to elect COBRA continuation coverage. For each qualified beneficiary who elects COBRA coverage, coverage will begin on the date that Plan coverage would otherwise have been lost. If you timely elect (and pay for) continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If you do not timely elect (and pay for) continuation coverage, your group health coverage under the Plan will end.

TAA Eligible Individuals

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA Eligible Individuals"). Under the new tax provisions, TAA Eligible Individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage.

TAA Eligible Individuals who did not previously elect continuation coverage during the original 60-day COBRA election period related to the TAA-related loss of coverage may elect continuation coverage during a second 60-day election period. This second 60-day election period begins on the first day of the month in which he or she is determined to be a TAA Eligible Individual, provided that such election may not be made later than 6 months after the date of the TAA-related loss of coverage. TAA Eligible Individuals may elect continuation coverage for themselves and their eligible family members. Any continuation coverage elected will begin with the first day of the second 60-day election period, and not on the date the coverage originally was lost. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has a 63-day break in coverage under HIPAA.

If you have questions about these new tax provisions or you are not sure whether you are a TAA Eligible Individual, contact the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also Available at:
www.doleta.gov/tradeact/2002act_index.asp

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of your health coverage under the Plan. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or the reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as follows:

(1) Disability Extension of 18 month Period on Continuation Coverage

The 18 month period of COBRA continuation coverage may be extended for up to an additional 11 months (for a total of up to 29 months of continuation coverage) if you or any family member covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage, provided that you notify the COBRA Administrator of the SSA determination within 60 days of the date of the determination and before the end of the initial 18 month continuation coverage period. The 11 month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to this notice requirement. Notice must be sent to the COBRA Administrator.

(2) Second Qualifying Event Extension of 18 month Period of Continuation Coverage

If your family member experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children may be eligible for additional months of COBRA continuation coverage, up to a maximum coverage period of 36 months. This extension is available to your spouse and dependent children if you die, become enrolled in Medicare (Part A, Part B, or both), or you get divorced or legally separated. This extension is also available to your dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you (or your family member) must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Administrator.

Early Termination of Continuation Coverage

The law provides that continuation coverage may be cut short prior to the expiration of the applicable 18, 29 or 36 month period for any of the following five reasons:

- (1) The group health coverage provided to you is terminated (and the plan sponsor is not required by COBRA to provide you with other group health coverage that it maintains, if any);
- (2)The premium for continuation coverage is not timely paid (within the applicable grace period);
- (3) The individual first becomes, after electing COBRA coverage, covered under another group health plan (as an employee or otherwise) that does not contain any preexisting condition exclusion or limitation applicable to the individual;
- (4) The individual first becomes, after electing COBRA coverage, enrolled in Medicare (Part A, Part B, or both); or
- (5) Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination. You are required to notify the COBRA Administrator within 30 days of any such final determination.

If you Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan office or you may contact the nearest Regional District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the Plan Informed of Changes

In order to protect your family's rights, you should keep the Plan office informed of any changes in the addresses of your family members and any changes in your marital status. You should also keep a copy, for your records, of any notices you send to the Plan office.

PRIVACY OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) gives you certain rights with respect to your health information, and it also imposes certain obligations on the Plan as a group health plan. The following describes the ways your health information is protected under HIPAA when that health information is disclosed to or used or disclosed by the Board of Trustees, in its capacity as the sponsor of the Plan. These rules do not apply to any disability, death, legal, educational or other non-health benefits provided under the Plan.

A complete description of your rights under HIPAA is available in the Plan’s Notice of Privacy Practices which the Plan is required to distribute to you. The statement that follows is not intended and cannot be considered to be the Plan’s Notice of Privacy Practices.

Your “protected health information” is information about you, including demographic information that-

- is created or received by the Plan, or by your health care provider or a health care clearinghouse (and is not related to your non-health benefits under the Plan, e.g., disability);
- relates to your past, present, or future physical or mental condition;
- relates to the provision of health care to you;
- relates to the past, present, or future payment for the provision of health care to you; and
- identifies you in some manner.

Since the Plan is required to keep your protected health information confidential, before the Plan can disclose any of your health information to the Board as the sponsor of the Plan, the Board must agree to keep your protected health information confidential. In addition, the Board must agree to handle your protected health information in a way that enables the Plan to comply with HIPAA. Toward that end, the Board hereby certifies that the Plan documents have been amended to incorporate the following provisions, and the Board agrees to the following rules in connection with your protected health information from the Plan:

The Board understand that the Plan will only disclose your protected health information to the Board for the Board’s use in Plan administrative functions and such disclosures explained in the Notice of Privacy Practices that will be distributed to you by the Plan. In all cases, the Board will receive only the minimum necessary amount of protected health information necessary for the Board to perform Plan administrative functions. Such Plan administrative functions may include assisting participants in filing claims for benefits under the

Plan, or filing an appeal of a denied claim with the appeals committee. The board may also receive protected health information as necessary for the Board to perform its fiduciary and administrative duties.

The Board will not use or disclose your protected health information for any reason other than for the plan’s administrative functions, as otherwise expressly permitted in this SPD, as required by law, or if the Board has your written authorization.

The Board will not use or disclose protected health information for employment-related actions or decisions or in connection with any pension or other employee benefit plan sponsored by the Board, unless it receives your express written authorization.

If the Board discloses to any of its agents or subcontractors any of your protected health information that it receives from the Plan, the Board will require the agent or subcontractor to agree to the same restrictions that govern the Board’s use of disclosure of your protected health information under this SPD.

The Board will promptly report to the Plan’s Privacy Officer if it becomes aware of any use or disclosure of your protected health information that is inconsistent with the uses and disclosures allowed under this SPD.

The Board will allow you or the Plan to inspect and copy your protected health information that is in its custody and control to the extent required of the Plan under HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to receive copies of your health information maintained by the Plan.)

The Board will make your protected health information available to you, or to the Plan in order to allow you or the Plan to amend the information, to the extent required under HIPAA, and the Board will incorporate any such amendments that the Plan has accepted in accordance with HIPAA. (You should review the Notice of the Privacy Practices to learn more about your rights to request an amendment to your protected health information maintained by the Plan.)

The Board will keep a written record of certain types of disclosures that it makes, if any, of your protected health information for reasons other than for your medical treatment, payment for that medical treatment, or health care operations, or with your written permission. This written disclosure record will include those types of disclosures made during at least the previous six years, except only disclosures made after April 14, 2003 must be listed. The Board

will make this disclosure record available to the Plan so that the Plan can provide you, upon request, with a copy of that list of disclosures. (You should review the Notice of Privacy Practices to learn more about your rights to request a log of certain types of disclosures of your protected health information made by the Plan.)

The Board will make available its internal practices, books and records relating to its use and disclosure of protected health information that it receives in its capacity as the sponsor of the Plan to the secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA.

The Board will, if feasible, return or destroy all protected health information received from the Plan in whatever form or medium (including any electronic medium under the Board's custody or control) when protected health information is no longer needed for the Plan's administrative functions for which the disclosure was made, and the Board will retain no copies. This includes all copies of any data or compilations derived from, and allowing identification of you or your beneficiary who is the subject of, the protected health information. If it is not feasible to return or destroy all of the protected health information, the Board will limit the use or disclosure of any protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Only the DC37 Health and Security Plan's employees may be given access to protected health information received from the Plan on behalf of the Board and these employees or workforce may only use your protected health information solely for the purpose set forth in this SPD.

Additionally, the individual Trustees will be permitted to have access to and use your protected health information, but only to perform the Plan's administrative functions that the Board provides for the Plan as described in this SPD.

If any of these employees, workforce or individual Trustees use or disclose your protected health information in violation of HIPAA and the rules set forth in this SPD, those employees and workforce or Trustees will be subject to disciplinary action and sanctions, up to and including the possibility of termination of employment or affiliation with the Board. If the Board becomes aware of any such violations, it will promptly report the violation to the Plan's Privacy Officer and will cooperate with the Plan to correct the violation, to impose appropriate sanctions and to mitigate any harmful effects on you.

There are also some special rules under HIPAA related to "electronic health information."

Electronic health information is generally protected health information that is transmitted by, or maintained, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses Internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, the Board will take additional action with respect to the implementation of security measures (as defined in 45 code of Federal Regulations §164.304) for electronic protected health information. Specifically, the Board will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

- Ensure that the adequate separation required to exist between the Plan and the Board is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;

- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect that information;

- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operation in its information system; and

- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.

How To Obtain Benefits

Before you can file a claim for any benefit in this booklet we have to find out who you are and whether you are covered. **THAT MEANS THAT YOU MUST FILE AN ENROLLMENT CARD WITH THE DC 37 HEALTH & SECURITY PLAN TRUST.** This card should be sent to the DC37 Health and Security Plan at 125 Barclay Street, New York, New York 10007, Attention: Eligibility and Enrollment Unit. This card provides all necessary information about you and your family.

If a death, marriage, domestic partnership, birth, adoption, divorce, separation or dissolution of domestic partnership has changed the size of your family, the Plan must be told of the changes. You inform the Plan by filling out a Change of Status form and providing the proper papers (birth, marriage, death certificates, etc.) to the DC 37 Health and Security Plan, at 125 Barclay Street, New York, New York 10007, Attention: Eligibility and Enrollment Unit. When a member completes an enrollment card a beneficiary is also designated for the Plan's Death Benefit. If a member experiences status changes as indicated above, or a previously named beneficiary has moved or is deceased, it is recommended that the member consider updating the Plan's records. Please note that the Plan cannot release the name of your beneficiary to you by phone or in writing. You can call the Plan office and request a change of beneficiary form. This form should be completed naming your current beneficiary of choice, signed, notarized and returned to the Plan office. Once the Plan has received this change of beneficiary form it will replace all previously submitted named beneficiaries. You must also advise the Plan of any change of address. You will not receive your prescription drug card or payment for a benefit claim if the Plan does not know your current address. Filing an Enrollment Card is the first step in receiving benefits.

After that has been done, you must comply with the following procedures for obtaining the particular benefits. In order to receive a benefit or obtain reimbursement for benefit expenses incurred, it is necessary to file the appropriate application or claim form with the Plan Office.

HERE'S HOW TO APPLY FOR YOUR BENEFITS:

All claim forms and participating provider listings are available from the Plan office. Call the Inquiry Unit claim forms line at (212) 815-1531. Detailed benefit information on eligibility and the status of claims you have filed is available by calling the Inquiry Unit's information line at (212)-815-1234. You may also access benefit information at the union's website,

www.dc37.net. In order to expedite claims processing, send completed claims to the Plan office at 125 Barclay Street, New York, New York, 10007.

SECOND SURGICAL CONSULTATION: Call the Plan at (212) 815-1355 regarding this benefit.

DENTAL BENEFIT: After any dental work or course of treatment has been completed, you and your dentist must fill out a dental benefit claim form. It must be filed within 30-days after the work is completed. Orthodontic claims may be filed quarterly. Please see dental section for pre-authorization requirements.

PRESCRIPTION DRUG BENEFIT: If you use a Participating Pharmacist, use your Prescription Drug Card. Have your doctor write the prescription on his/her prescription drug form and bring both the form and card to the Participating Pharmacist. If you do not use the Prescription Drug Card, you and the pharmacist must fill out the direct reimbursement claim form. The completed direct reimbursement claim form must be filed within 30-days after you have paid for the drugs.

OPTICAL BENEFIT: If you use a Participating Optometrist or Optician, all you need is a Voucher from the Plan office. If you do not use a Voucher, you and the Optometrist or Optician and you must fill out a direct reimbursement form that must be filed within 30-days after you have paid for your glasses.

DEATH BENEFIT: The Plan office should be notified of the death of a covered retiree by phone or letter. The appropriate claim forms will be sent to the named beneficiary. If a retiree is not survived by any beneficiaries or has failed to name any beneficiaries, then the benefit will be paid according to the rules and regulations of the Plan. These forms must be returned to the Plan with a certified death certificate, within 30-days.

Members are reminded that claims must be filed in a timely manner. If the claim is filed late, a written excuse for the late filing must be submitted before the claim will be considered for payment. The Plan cannot and will not pay any claim, regardless of excuse, if the claim is filed more than 90 days after the first day a claim could have been filed. Remember: You are responsible for filing the claim and not your health care provider.

Coordination Of Benefits

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same expense. To avoid this costly problem, your health plan provides a Coordination of Benefits (“COB”) provision.

When dual coverage exists, the following rules shall apply for determining how benefits will be coordinated between this Plan and another plan:

1. A member will be primarily covered for benefits under the DC 37 Health & Security Plan.
2. A member’s spouse will be primarily covered for benefits under the spouse’s separate plan.
3. A member’s dependent child will be primarily covered for benefits under the Plan which covers the parent whose birthday occurs first in the year.
4. When both parents are covered by the Plan, the children will be covered by the Plan of the parent whose coverage is more comprehensive. When both parents are covered by the Plan and the coverage is equal, the children will be covered under the father’s plan. Each member will only be covered under his/her plan.

When dual coverage exists, the following rules of payment shall apply:

1. When this Plan provides primary coverage to the member and eligible dependents, the Plan will pay full benefits, up to the Plan’s maximum coverage.
2. When this Plan provides secondary coverage to an eligible dependent, the Plan will pay the difference between the dependent’s out-of-pocket costs or the usual and customary cost for the covered treatment, service or Prescription Drugs, whichever is lower, and the amount of reimbursement or payment received by or on behalf of the eligible dependent from the other plan.

If you need medical treatment, dental treatment or prescription medication, etc. because of an accidental injury for which those medical, dental or prescription drug expenses are covered by No-Fault, Home Owner’s Liability Insurance, etc. then that insurance coverage shall be primary and the Plan will be secondary.

If the Plan has paid you any benefits because of the negligence or other wrongdoing of a party, and you sue that party for hospital bills, medical bills, loss of earnings, etc. then you must sign an Assignment for Benefits in favor of the Plan, as a condition of receiving your benefits, so that the Plan can be reimbursed in full in the event you obtain a recovery against that party.

Reimbursement under the Prescription Drug Benefit, regardless of whether the Plan is the primary or secondary carrier, will not exceed the Plan’s allowance of a prescription drug, minus the co-payment, or the actual out-of-pocket cost of the Prescription Drug, whichever is lower. If the primary carrier has paid less than the Plan’s allowance, the Plan will pay the difference, but no additional payment will be made by the Plan if the primary carrier has reimbursed up to the Plan’s allowance.

Coordination of Benefits and Medicare Part D Drug Plan Enrollment:

The Plan will not cover the cost of prescription drugs for a retiree, spouse or dependent if covered through enrollment in a Medicare Part D Drug Plan. The Medicare Part D Drug Plan will be considered Primary and the Plan will provide benefits after the enrolled retiree, spouse or dependent provides an explanation of benefits statement (EOB) meeting the Med D Plan annual limit or coverage gap.

Municipal Employees Legal Services Benefit

WHAT IS THE MUNICIPAL EMPLOYEES LEGAL SERVICES BENEFIT?

The Municipal Employees Legal Services Benefit is a program of personal legal services for active employees, eligible retirees, resignees and their dependents.

The Plan utilizes the staff of lawyers and supporting staff maintained by the District Council 37 Health and Security Plan's Municipal Employees Legal Services (MELS) to serve its members. Staff professionals advise, counsel and represent members on covered matters. The lawyers are licensed to practice law in New York. They work full time for MELS, and are not permitted to have an outside law practice.

Because legal problems are often closely linked to personal and financial concerns, the staff also includes social workers to help clients with such concerns.

ELIGIBILITY

To determine if you are eligible for legal services turn to page 1.

YOUR LEGAL SERVICE BENEFITS

For eligible retirees and resignees, the Plan's legal services include advice, counseling and representation, including court appearances when necessary, for the following kinds of legal matters, provided these matters do not arise from any business ventures you may be involved in.

Representation will not include appeals, except that if a judgment obtained by the Plan is appealed by the other party, the Plan will represent you in opposing that appeal.

WILLS

A Plan lawyer will prepare wills, health care proxies, living wills and durable powers of attorney for you and your spouse or domestic partner.

DEBT PROBLEMS

If you have debt problems resulting from loans (including a mortgage loan on your house), installment contracts, collection actions against you by creditors, or any other financial obligations which you are unable to meet, the legal staff will give you advice and counsel, and will represent you if you are sued for more than \$500 and have a legal defense.

If bankruptcy is advisable in your situation, the Plan will provide counseling and represent you in a bankruptcy proceeding.

PURCHASE OF GOODS AND SERVICES

You may consult a Plan lawyer for advice and counsel on any dispute you have with a seller over merchandise or services you have bought.

If you have a claim to bring, the Plan will represent you if the amount in dispute exceeds the monetary jurisdiction of Small Claims Court. If the amount is within Small Claims jurisdiction, the Plan will refer you to Small Claims Court and advise you on how to represent yourself there most effectively.

If your claim is over \$500 and within Small Claims jurisdiction, the Plan will first try to negotiate a settlement for you before referring you to Small Claims Court.

EVICTIONS

The Plan will represent you in any action your landlord brings against you which might result in your eviction from your primary residence.

DIVORCE, SEPARATION AND ANNULMENT

You may come to the Plan for consultation and representation in divorce or civil annulment proceedings and for the preparation of separation agreements. The Plan provides services to you in these matters including representation regarding maintenance support, custody, visitation rights, and property division.

DOCUMENT REVIEW

You can avoid a lot of legal problems by asking for a lawyer's advice before you sign any written agreements, particularly if the sum of money involved is substantial. If such documents concern covered matters, a Plan lawyer will review them and advise you. The Plan will review documents in matters such as consumer purchases, home improvement contracts, loans and leases, purchases of one or two family houses, co-op apartments or condominiums and insurance.

CREDIT RATING

The Plan will help you correct inaccurate information on your credit report. If you have been denied a loan or other credit because of your credit rating, The Plan will help you to obtain the credit report from a credit reporting agency. If any items are inaccurate, the Plan will seek to have the credit reporting agency correct them.

PUBLIC UTILITIES

The Plan will help you with your billing disputes with electricity, gas and telephone companies provided the amount in controversy exceeds \$500. If your services have been shut off, or if the utility is threatening to shut off services, the Plan will give you legal assistance without regard to the amount in controversy.

GOVERNMENT AGENCIES-ENTITLEMENTS

The Plan will advise and counsel you on securing your entitlements from government agencies, and will also represent you in hearings before those agencies, in any dispute over benefits provided the amount in controversy exceeds \$500.

OTHER ADMINISTRATIVE AGENCY MATTERS

1. The Plan will represent you in administrative hearings with public housing. The Plan will also assist you in determining whether your rent in public housing is correct. The Plan will also assist you in applying for and transferring within public housing, and in applying for housing subsidies, if there have been disputes regarding your application for these benefits.
2. If you are eligible because of your age or income, the Plan will help you obtain an exemption from a rent increase, (SCRIE), if you have been denied this benefit.
3. The Plan will represent eligible members of your family in public school suspension matters involving disciplinary charges, and in special education placement.
4. The Plan will help you correct errors in your birth certificate if you were born in New York State.

DEFENDING TORT LAWSUITS

The benefit for the defense of tort matters is limited to the payment of reasonable attorney fees, not to exceed \$300. No benefit is provided without prior written approval by the Plan, and unless the amount demanded is in excess of \$500. You are not entitled to this benefit if you are entitled to representation under an existing insurance policy, or are otherwise required by law to have an insurance policy.

CITIZENSHIP

The Plan will help you apply for citizenship if you are a permanent resident of the United States.

ADDITIONAL LEGAL BENEFITS FOR:

- Pensionable Former Full Time Employees
- Pensionable Former Part Time Employees
- Pensionable Former Department of Education Hourly Employees
- Non-Pensionable Former Department of Education Hourly Employees
- Pensionable Former School Crossing Guards
- Former Family Auxiliary Employees from the

Teacher's Retirement System

* The following benefits are not available in the Non-Pensionable Former School Crossing Guards package.

REAL ESTATE TRANSACTIONS

The Plan will represent you in the transaction involved in buying or selling a one-family house or co-op apartment or condominium, which is your main residence. The Plan will also represent you in buying a two-family house which is your main residence.

FAMILY COURT MATTERS

The Plan will advise and represent you in disputes over custody, visitation and paternity of children, and will provide representation of a parent (or a relative acting in the parent's place) in child neglect, abuse or foster care cases. Representation of foster parents will be limited to those foster parents having had custody of a child for more than 24 months. The Plan will provide advice only on support matters.

The Plan also covers cases involving spouse abuse and other domestic violence, helping to obtain orders of protection and related relief. Representation will not include cases brought in Criminal Courts.

ADOPTION

The Plan will represent you in a proceeding for an adoption of a minor child.

GUARDIANSHIP

The Plan will represent you in obtaining letters of guardianship over a minor child.

CHANGE OF NAME

The Plan will represent you in a proceeding to change your name.

SOCIAL WORKERS

If you wish, your lawyer will refer you to a social worker if the personal or social problem you want to talk over with the social worker is related to the legal problem you are discussing with the lawyer. Ask your lawyer about this service.

LIMITATIONS ON THE BENEFIT

Even if you are eligible for the legal services benefit, there are some limitations on when you can use the benefit because of a conflict of interest or prior representation. These limitations are:

1. Dispute between covered employee and spouse or domestic partner, covered employee and dependent child.
Lawyers cannot represent both sides of a dispute because to do so would be a conflict of interest. Accordingly, if a dispute arises between two

members of your family who would otherwise both be entitled to representation by the Plan, MELS will represent only the covered employee. For example, if you are the covered employee and you came to the Plan for a divorce, MELS would represent you but would not represent your spouse.

2. Dispute between two covered employees.

If the dispute is between two covered employees, or between two covered retirees, or between a covered employee and a covered retiree, the Plan will not represent either party. Instead, the Plan will pay reasonable fees, not to exceed \$300, for an outside attorney for each employee or covered retiree entitled to representation. This will also be true if husband or wife seeking divorce or separation are both covered employees, or both covered retirees, or one is a covered employee and the other is a covered retiree.

The Plan will not pay more than \$450 in one year towards the total cost of outside legal fees for the family of any covered person eligible for this benefit.

You must apply and receive approval for this payment before incurring the legal fee..

PRIOR REPRESENTATION

The Plan will not represent you in a matter in which you have previously received representation from another lawyer.

HOW TO SEE YOUR LAWYER

To make an appointment to see a Plan lawyer. Call (212) 815-1111. Your call will be answered by a legal assistant. Please be ready to give this person your social security number. You may also be asked for your present job title and the name of the institution you work for.

If you are calling for an appointment and you are the spouse or domestic partner of an eligible employee or retiree, you should be prepared to give this same information about your spouse or domestic partner.

The legal assistant will also ask you some questions about your legal problem to be sure it is one that is covered by the Plan benefit. If you are eligible, and your problem is covered, you will be given an appointment as soon as possible.

IF YOU HAVE A REAL EMERGENCY AND CAN'T WAIT

Be sure to explain your situation when you call for an appointment. If you are eligible and the problem is covered, you will be given an appointment early enough to take care of the emergency.

WHAT YOUR PLAN LAWYER WILL DO FOR YOU

Your lawyer will talk with you about your problem, and give you advice. S(he) will prepare documents

for you, as needed, and will also represent you in court, if necessary.

THE COST OF THESE SERVICES

There is no charge to you for any of the services the Plan provides to advise or represent you. You may have to pay court filing fees, fees to serve summonses, and any other disbursements related to your case that are not part of the professional services. Your lawyer will tell you how much they are.

WHERE YOU WILL BE REPRESENTED

Your Plan lawyer will represent you in the five counties of New York City, Westchester, Nassau, Western Suffolk and Rockland Counties (within a 50-mile radius of the New York office). In addition, you must live within the MELS service area.

As of June 30, 1992, the Internal Revenue Code required that the value of employer-funded group legal services benefits be considered as gross income to each covered member. The contributing employer's contribution for the value of the MELS benefit will be added to your income and reflected on your W-2.

THESE SERVICES ARE CONFIDENTIAL

The Plan's lawyers are bound by strict rules of professional ethics not to disclose anything about your problem to anyone else without your permission.

BENEFIT EXCLUSIONS

Any matters not listed as covered on pages 37 to 38 are excluded. Some examples of the kinds of problems which are excluded are:

1. Criminal matters, including juvenile delinquency;
2. Matters relating to business, commercial and professional ventures in which you or your family are personally involved;
3. Matters relating to other income-producing ventures, including landlord-tenant disputes where you are the landlord;
4. Matters which would commonly be handled by a private lawyer on a contingent fee (percentage) basis, such as suits for libel, slander, malpractice, personal injury, or property damage;
5. Matters arising out of ownership, control or use of a vehicle; parking and moving violations;
6. Claims against DC 37 or any of its affiliated organizations, Health and Security Plan officers and staff, the City of New York and related agencies and the State of New York in their employer capacity, and their respective pension funds;
7. Disputes between other employers and their employees, including matters related to such employment, such as pension and benefit entitlements;

8. Immigration matters other than citizenship, tax matters, patent and copyright, probate and administration of estates;
9. Disputes between landlord and tenant not leading to eviction;
10. Matters in which legal services are available through insurance, or where insurance is mandated by law, or where representation is available to the covered member under other group legal plans;
11. Matters involving union-administered health, education or other benefit plans, such as DC 37 Med Team/GHI. However, Blue Cross, Blue Shield, HIP and GHI matters will be handled where such representation will not involve claims against DC 37 and its related Funds;
12. Representation in the purchase or sale of a multiple dwelling;
13. Representation in small claims court.

TERMINATION OR SUSPENSION OF LEGAL SERVICE BENEFITS

Except for representation in litigation, which will continue for 30 days after eligibility ceases for the purpose of winding up a case or substituting another

attorney, the Plan will terminate your legal service benefits:

1. When you leave the employer's payroll;
2. When you are transferred to a job title not covered by the Plan;
3. When you retire without becoming a covered retiree;
4. When a benefit is discontinued by the Plan;
5. When the Plan itself is terminated; or
6. When the Trustees determine in their sole and absolute discretion, that you have engaged in conduct which warrants suspension or termination of benefits as described in the Section "Defrauding the Plans" found in the General Information with respect to Plan Administration.

GENERAL INFORMATION FOR ALL BENEFITS

IF A BENEFIT IS DENIED

Some benefits are denied, either because of improper filing, because your benefit claim is not covered, or because of ineligibility for the benefit. If your benefit is denied, you may want to contest the denial.

The claimant shall address and mail a letter to the appropriate Plan Administrator of the District Council 37 Health & Security Plan, or the MELS Chief Counsel at its main office 125 Barclay Street, New York, New York 10007 stating:

- the type or nature of his claim;
- the reason it was denied;
- the reasons why the claimant believes his claim should be accepted; and any other information that he feels should be considered on the appeal. This appeal must be filed within 180 days from receipt of the rejection notice.

The following sections provide specific information regarding claim decisions, time frames and your right to appeal adverse benefit determinations.

INITIAL DECISIONS AND TIME FRAMES

Catastrophic Medical Benefit, Dental Benefit, Optical Benefit, Audiology Benefit, Podiatry Benefit, Legal Services Benefit, Personal Services Care Benefit and Prescription Drug Benefit

The Participant shall be notified of any adverse benefit determination within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 30-day period, the plan notifies the Participant of the reasons for the extension and of the date by which the Plan expects to render a decision. If the extension is needed because the Participant did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give the Participant at least 45 days from receipt of the notice to provide it.

Dental Benefits and Prescription Drug Benefits Requiring Pre-Certification

For claims requiring pre-certifications, the Participant will be notified of the Plan's benefit determination (whether adverse or not) within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 15-day period, the Plan notifies the Participant of the

reasons for the extension and of the date by which the Plan expects to render a decision. If the extension is needed because the Participant did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. If the claim is improperly filed, the Plan will provide notice of the failure within 5 days.

Disability Benefit

If the Participant's claim for Supplemental Disability benefits is denied in whole or in part for any reason, then within 45 days after this Plan receives the claim, this Plan will send the Participant written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the Plan. For any extensions, the Plan will provide advance written notice indicating the circumstances requiring the extension and the date by which the Plan expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and the Participant shall be afforded at least 45 days within which to provide specified information (if applicable).

Death Benefit, Accidental Death, and Dismemberment and Loss of Sight Benefit

If the Participant's claim for a Death Benefit or Accidental Death and Dismemberment and Loss of Sight Benefit is denied in whole or in part for any reason, then within 90 days after this Plan receives the claim, this Plan will send the Participant written notice of its decision, unless special circumstances require an extension, in which case the Plan will send the Participant written notice of the decision no later than 180 days after the Plan receives the claim. If an extension is necessary, the Participant will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination.

Initial Adverse Benefit Determination Notice

In an initial notification of adverse benefit determination, the initial notification shall set forth:

1. The specific reasons for the adverse determination;
2. Reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for the Participant to complete the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures;
5. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
6. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the Plan's terms to the Participant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Appeals of Adverse Benefit Determinations

The Plan provides for a two level process of appeals of adverse benefit determinations, the first level is to the Administrator and the second level is to the Board of Trustees.

Administrative Appeals

If the Participant is not satisfied with the reason or reasons why the claim was initially denied, then the Participant may appeal to the Administrator. To appeal an adverse benefit determination of a Death Benefit, or an Accidental Death and Dismemberment and Loss of Sight Benefit claim, the Participant must write to the Administrator within 180 days after receiving the Plan's initial adverse benefit determination. To appeal an adverse benefit determination of a Catastrophic Medical Benefit, Dental Benefit, Optical Benefit, Audiology Benefit, Podiatry Benefit, Legal Services Benefit, Prescription Drug Benefit, Personal Services Care Benefit, or Disability Benefit, the Participant must write to the Administrator within 180 days after receiving this Plan's initial determination.

The Participant's correspondence (or his representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY MY BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20 ____." If this statement is not included, then the Administrator may not understand that the Participant is making an appeal, as opposed to a general inquiry. If the Participant has chosen someone to represent him in making his appeal, then the letter (or the representative's letter) must state that the Participant has authorized him or her to represent the Participant with respect to the

appeal, and the Participant must sign such statement. Otherwise, the Administrator may not be sure that the Participant has actually authorized, a representative to represent him and the Administrator does not want to communicate about the Participant's situation to someone unless they are sure he or she is the Participant's chosen representative.

The Participant shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. The Participant shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, in regard to all appeals other than those involving the Death Benefit, Accidental Death and Dismemberment and Loss of Sight Benefit, Legal Services Benefit, Personal Services Care Benefit, or Disability Benefit: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Board of Trustees Appeal

If the Participant is not satisfied with the reason or reasons why the appeal to the Administrator was denied, then the Participant may appeal to the Board of Trustees. To appeal an adverse benefit determination of a Death Benefit, or an Accidental Death and Dismemberment and Loss of Sight Benefit claim, the Participant must write to the Board of Trustees within 60 days after receiving the Plan's first level appeal determination. To appeal an adverse benefit determination of a Catastrophic Medical Benefit, Dental Benefit, Optical Benefit,

Audiology Benefit, Podiatry Benefit, Legal Services Benefit, Prescription Drug Benefit, Personal Services Care Benefit, or Disability Benefit, the Participant must write to the Board of Trustees within 60 days after receiving the Plan's first level appeal determination.

The Participant's correspondence (or the representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY MY BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20 ____." If this statement is not included, then the Board of Trustees may not understand that the Participant is making an appeal, as opposed to a general inquiry. If the Participant has chosen a representative to represent him in making the appeal, then the letter (or the representative's letter) must state that the Participant has authorized him or her to represent the Participant with respect to the appeal, and the Participant must sign such statement. Otherwise, the Board of Trustees may not be sure that the Participant has actually authorized someone to represent him and the Board of Trustees does not want to communicate about the Participant's situation to someone unless they are sure he or she is the Participant's chosen representative.

The Participant shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. The Participant shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, in regard to all appeals other than those involving the Death Benefit, Accidental Death and Dismemberment and Loss of Sight Benefit, Legal Services Benefit, Personal Services Care Benefit, or Disability Benefit: (1) the review will not afford deference to the initial adverse benefit determination nor the first level appeal determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the

individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

DETERMINATIONS ON APPEAL

Time Frames for Administrator Appeals

Dental Service or Prescription Drug Benefits Requiring Pre-certifications:

The Participant will be notified of the Administrator's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review.

All Other Claims:

The Participant will be notified of the Administrator's decision within a reasonable period of time, but not later than 60 days after receipt of the request for review.

Time Frames for Board of Trustee Appeals

The Trustees at their next regularly scheduled meeting will make a determination of the appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, the Participant will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify the Participant of the benefit determination not later than 5 days after the determination is made.

CONTENT OF ADVERSE BENEFIT DETERMINATION ON REVIEW

Administrator Appeals

The Plan's written notice of the Administrator's decision will include the following:

1. The specific reasons for the adverse benefit determination;
2. Reference to specific Plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will

provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

5. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request, and
6. a description of the Plan's appeal procedure and the time limits applicable to such procedures.

Board of Trustee Appeals

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;
2. Reference to specific Plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the

adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

5. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

Trustees' Decisions are Final and Binding

The Trustees' final decision with respect to their review of the Participant's appeal will be final and binding upon the claimant because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying the appeal is deposited in the mail to the last known address of the Participant.

GENERAL INFORMATION WITH RESPECT TO PLAN ADMINISTRATION

The District Council 37 Benefits Fund is established pursuant to the City-Wide collective bargaining agreement between the City of New York and District Council 37 AFSCME. It receives all welfare contributions under the various collective bargaining agreements which have been entered into by the City of New York and Related Agencies and District Council 37 and its affiliated locals.

The Benefits Fund uses the money it receives to fund, in its discretion; the DC 37 Health and Security Plan, which, in turn, provide you with benefits described in this booklet. The Fund is a legal entity separate and distinct from the Union. MELS is now a division of the DC 37 Health & Security Plan and it is not a separate entity.

1. The day-to-day operation of the Plan is managed by Administrators who are appointed by the Trustees. The Administrator and the MELS Chief Counsel are also the agent for service of legal process upon its Plan by any person who may be asserting a legal claim against the Plan for benefits. The address for the Administrator and the MELS Chief Counsel is 125 Barclay Street, New York, New York 10007.
2. From time to time you may have questions concerning your coverage or the present status of a benefit which you have filed for. Under those circumstances, you should contact the Inquiry Unit of the appropriate Plan by writing to them at the Plan address or by telephone. In the event they cannot answer your questions, they will put you in contact with the person or persons who can do so.
3. As we have previously noted for you, these Plans are funded through monies received on your behalf under various collective bargaining agreements. Upon written request, the Administrator of the Plan or the Chief Counsel of MELS shall make available for your inspection the various documents (such as the Trust, collective bargaining agreement, etc.) which govern the structure of the Plan. These documents may be examined by you at the Plan's office during the regular business hours of the day (9 a.m. to 5 p.m.) by an appointment made on receipt of your written request. In addition, the Plan will make copies of any of these documents available for your use upon payment by you of the reasonable costs of duplicating the ones you may select. Examples of the costs involved would be as follows: The Health & Security Plan Document \$5 (at the Plan office); Municipal Employees Legal Services Document \$1 (at the MELS office). Printed and bound Summary of the Plans (this booklet) no charge. Photocopies or otherwise reproduced copy of Trust Instrument, Collective Bargaining Agreement, etc., 10 cents per page.

4. This Booklet is designed to explain the benefits provided by the Plans. However, the Plans are administered in accordance with the Health & Security Plan Document; and the MELS Benefit Document ("Document(s)"). This Summary Plan shall not, in any manner or provision, be inconsistent with or contradict any aspect of the said Documents. In such event the provisions of said Documents shall govern and apply as if a part of this Summary. Under no circumstances shall the Plans be liable for any inconsistencies or contradictions between this Summary Plan Description and the Documents.
5. The Plan currently files reports with the Internal Revenue Service, the Comptroller's Office, and other governmental agencies on a fiscal year basis which begins the first day of July of each year and ends the thirtieth day of the following June. The books and records of the Plan are kept on the same fiscal year basis. These books and records are annually audited by independent certified public accountants and reports of these audits are submitted to the Comptroller of the City of New York.

AMENDMENT AND TERMINATION

The Board of Trustees reserves the right in its sole and absolute discretion, to amend, modify, terminate the Plan, or any benefits (including retiree benefits) provided under the Plan, in whole or in part, at any time and for any reason, pursuant to a vote of the Board of Trustees. If the Plan is amended, modified, terminated, you, your family, and other active or retired employees might not receive benefits as described in this booklet. This may happen at any time—even after you retire -- if the Board of Trustees decides to amend, modify, or terminate the Plan. It is also possible that you will lose all benefit coverage. For example, your coverage will terminate if the Board of Trustees terminates the Plan or if your coverage under the Plan terminates in accordance with applicable law. In no event will active or retired employees (or their dependents) become entitled to any vested rights under the Plan.

INTERPRETATION

The Board of Trustees has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan and to decide all matters arising there under. Such decisions would include, but would not be limited to, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan, and the right to resolve any ambiguities, inconsistencies or omissions in Plan documents or language. All determinations made by the Board of Trustees with respect to any matter hereunder shall be final and binding on all persons.

DEFRAUDING THE PLANS

The Board of Trustees has the right to suspend a member's benefits, and put that person on "Refund Due" if any of the following occurs:

- A. A claim is submitted or a member received a benefit through false representation of a material fact.
- B. A member received a benefit through an administrative error and when notified of the error, refuses to pay back to the Plan the sum in question.

Procedure for Invoking Refund Due Status

If the DC37 Health & Security Plan believes that a member has obtained a benefit through false representation or that the member has received a benefit through an administrative error, then the Plan will notify the member in writing and request from the member a written response.

Within 10 days from the receipt of the letter described above, the member is expected to respond in writing detailing the reason why he/she should not be placed on "Refund Due" status.

If, after reviewing the response, the Plan still believes that the member should be placed on "Refund Due" status, or if the member does not respond within a reasonable amount of time, then the Plan will notify the Hearing Officer who will send a written notice to the member that he/she may appear at a hearing at a designated time in order to explain why he/she should not be placed on "Refund Due" status.

If a hearing is conducted, or if the member declines to attend a hearing and otherwise fails to make restitution to the Plan, the Hearing Officer will make a written recommendation to the Plan Administrator as to whether the member should be placed on "Refund Due" status. The Plan Administrator has the power to place the eligible participant on "Refund Due" status. The Plan Administrator will review the recommendation and if the record warrants placing the member in "Refund Due" status the member will be notified in writing of the determination.

Any member placed in "Refund Due" status will be instructed in writing how to make restitution by paying the amount owed or by offsetting the amount owed against claims incurred and submitted.

Any member placed in "Refund Due" status has the right to appeal by filing a written appeal to the appropriate Board of Trustees within 30 days of receipt of the notice of being placed in "Refund Due" status. An appeal to the Board of Trustees is the

final appeal of being placed in "Refund Due" status. The determination made by the Board of Trustees will be given to the Plan Administrator, who will notify the member in writing.

A member placed in "Refund Due" status and all dependents will be ineligible to receive benefits from the Plan until such time as the Plan has offset the amount owed against claims submitted or the member has repaid the Plan.

The Plan Administrator will send written notice of "Refund Due" status to the affected member once per year.

Where appropriate, the Board of Trustees will have the power to sue the member for non payment and any interest or fees that occurred.

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections.

You have the right to examine or request copies of all documents governing the plan. (see General Information with Respect to Plan Administration)

You have the right to continue health care coverage under the plan as a result of a qualifying event.(see COBRA section)

You have the right to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage.(see Certificate of Creditable Coverage)

CERTIFICATE OF CREDITABLE COVERAGE

Under federal law, health plans may deny coverage for pre-existing conditions only under limited circumstances and for a limited period of time. If a health plan does deny pre-existing condition coverage for the permitted time period, that period may be reduced by periods of prior health coverage, as long as the new coverage starts within 62 days of the date the prior coverage ended.

When your coverage ends, you are entitled to receive a certificate of creditable coverage showing your period of coverage under the Benefit's Plan. This certificate can be used to reduce (or possibly eliminate) a pre-existing condition period under your new health coverage. This certificate is provided to you on your request. Please contact the DC 37 Health & Security Plan's Inquiry Unit at 212-815-1234.

NOTICES

This certificate is of value to you. It should be kept in a safe place.

As soon as your benefits end, you should consult your employer to find out what rights, if any, you may have to continue your protection.

If you or your dependents had coverage under a prior plan of benefits, please check with the Plan office to determine if there are any additional provisions which affect your benefits under this plan. The fact that a provider may recommend that a covered person receive a dental, vision, audiology, podiatry or prescription service does not mean:

1. That the service will be deemed to be necessary, or
2. That benefits under this plan will be paid for the expenses of the service.

The DC 37 Health & Security Plan will make the decision as to whether the dental or vision service:

1. Is necessary in terms of generally accepted; and
2. Is qualified for benefits under this plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is an order or judgment from a state court or administrative body directing the DC 37 Health & Security Plan to cover a child under a group health care plan. Federal law requires that the QMCSO must meet certain form and content requirements, and be delivered to the plan administrator in order to be valid. If you have any questions or would like to receive a copy of the written procedures for determining whether a QMCSO is valid, please contact the Plan office.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Act (USERRA) requires that health plans offer continuous coverage for up to 18 months to persons who are absent due to military service. The health plan may not require the person to pay any more than the employee share for that coverage if the period of military service does not exceed 31 days. If the period extends beyond 31 days, the employee may be required to pay not more than 102 percent of the full premium under the plan.

Titles Eligible For Benefits

FORMER EMPLOYEES OF THE "CITY" OR A "RELATED AGENCY" (listed in "Who Is Eligible For These Benefits") WHO WERE IN A TITLE COVERED BY A COLLECTIVE BARGAINING AGREEMENT OR A COMPTROLLER'S DETERMINATION WHICH PROVIDES FOR A CONTRIBUTION TO BE MADE TO THE PLAN ARE ELIGIBLE FOR BENEFITS.

AN UPDATED PLAN BOOK TITLE LISTING IS AVAILABLE AT THE PLAN OFFICE -- YOU MAY CALL (212-815-1234) AND VERIFY IF YOUR TITLE IS COVERED.

IF YOU WISH A COPY OF THE LATEST LISTING, IT WILL BE MADE AVAILABLE TO YOU FOR \$10, OR 10 CENTS A PAGE.

**DISTRICT COUNCIL 37
HEALTH AND SECURITY PLAN
NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

**If you have any questions about this notice, please contact:
The District Council 37 Health and Security Plan Inquiry Unit
125 Barclay Street, 3rd Floor
New York, New York 10007
(212) 815-1234**

Effective Date: April 14, 2003

The Health and Security Plan of District Council 37 (the "Plan") is required by law to put in place reasonable measures that protect the privacy of your health information ("individually identifiable health information") that is transmitted or maintained by the Plan in any form. This health information is considered protected health information ("PHI"). The Plan also is required to give you this notice of its legal duties and privacy practices related to your PHI. It is required to abide by the terms of this notice as currently in effect. The Plan has designated itself as a hybrid entity. As a hybrid entity, all of the Plan's functions are covered functions that will comply with the federal regulations commonly referred to as HIPAA's privacy rules except the Municipal Employees Legal Services benefit (MELS). Because MELS does not perform functions related to health care, MELS's operations will be separate from those of the Plan, and MELS will not need to comply with HIPAA. (HIPAA is the Health Insurance Portability and Accountability Act.)

The Plan has the right to change its privacy practices and to change the terms of this notice to reflect those changed practices. The Plan has the right to make the new notice provisions effective for all PHI that it maintains. The Plan will make a copy of the most recent notice available upon request. To request a copy, contact the DC 37 Health and Security Plan Inquiry Unit, 125 Barclay Street, New York, New York 10007 at (212) 815-1531. If the Plan makes a material change to the permitted or requested uses and/or disclosures of your PHI, or your rights explained in this notice, or the Plan's legal duties or other privacy practices stated in this notice, the Plan will distribute a revised notice within sixty (60) days of that type of change.

This notice is general in nature, and it includes information related to federal privacy regulations that affect health plans and other organizations that provide or pay for health care. Therefore, some of the information provided in this notice may apply to circumstances that do not often arise in the daily operation of the Plan.

A. OBLIGATIONS OF THE PLAN TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The Plan is required to use and/or disclose your PHI:

1. To you when you ask for it or ask to see to whom it has been disclosed (you exercise your "right of access" and/or "right to an accounting") (see Section "D" below) and
2. To the Secretary of the U.S. Department of Health and Human Services if there is an investigation and/or a determination of the Plan's compliance with federal privacy law.

B. RIGHTS OF THE PLAN TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

The Plan has the right to use and/or disclose your PHI:

- 1. Treatment** - to provide you with treatment and to coordinate or manage your health care. For example, the Plan may disclose to your oral surgeon the name of your dentist so they are able to confer about your care and share information to treat you.
- 2. Payment** - for any reason related to payment for your medical treatment and/or services including, but not limited to, making determinations of eligibility or coverage and to certain other persons or companies that perform services related to payments for the Plan. For example, the Plan may inform a doctor of your eligibility for medical coverage.
- 3. Health Care Operations** - to support the Plan's operations and to certain other persons or companies that perform services related to the Plan's operations. For example, it may use your PHI to conduct quality assessment and improvement activities, to secure or place a contract for reinsurance of risk relating to health care claims, or to refer you to a disease management program.
- 4. Treatment Alternatives** - to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, the Plan may use your PHI to contact you regarding participation in an asthma management program.

C. OTHER CIRCUMSTANCES WHEN THE PLAN MAY USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

The Plan may use and/or disclose your PHI:

- 1. As Required By Law** - when required to do so by federal, state or local law.
- 2. Public Health Risks** - for public health activities. Your PHI can be used by public health officials:
 - to prevent or control disease, injury or disability;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to collect or report reactions to medications or problems with products;
 - to track Food and Drug Administration-regulated products;
 - to enable product recalls, repairs, replacement or lookback, including notifying people of recalls of products;
 - to conduct post-marketing surveillance; or
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- 3. Reporting Victims of Abuse, Neglect or Domestic Violence** - to notify a government authority if the Plan reasonably believes you are a victim of abuse, neglect or domestic violence. The Plan may disclose your PHI if the disclosure is required by law or if you agree to the disclosure.
- 4. Health Oversight Activities** - to a health oversight agency for activities authorized by law, including audits, investigations, inspections and licensure.
- 5. Judicial and Administrative Proceedings** - in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if reasonable efforts have been made to inform you about the request or to secure a qualified protective order.

6. **Law Enforcement** - for certain law enforcement purposes, including the following:
 - to comply with a court order, subpoena, warrant, summons or similar process;
 - to identify or locate a suspect, fugitive, material witness or missing person;
 - to comply with requests for information pertaining to you if you are the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain your assent;
 - to comply with reporting requirements or report emergencies or suspicious deaths;
 - to report crimes that occurred on our premises; or
 - in emergency circumstances to report: (i) a crime; (ii) the location of the crime or victims; or (iii) the identity, description or location of the person who committed the crime.
7. **Coroners, Medical Examiners and Funeral Directors** - to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. The Plan may also disclose your PHI to funeral directors as necessary to carry out their duties.
8. **Organ and Tissue Donation** - to organ procurement organizations or other organizations involved in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
9. **Research** - under certain circumstances, for research purposes. Your PHI will only be used and/or disclosed: (i) if the privacy aspects of the research have been reviewed and approved by a special privacy board or institutional review board; (ii) if the researcher collects your PHI to prepare for a research proposal; (iii) if the research occurs after your death; or (iv) if you authorize the use and/or disclosure of your PHI.
10. **To Avert a Serious Threat to Health or Safety** - when necessary to prevent a serious threat to the health and safety of the public or another person. Any disclosure, however, would only be to a person reasonably able to prevent or lessen the threat.
11. **Armed Forces** - if you are a member of the armed forces, as required by military command authorities. The Plan may also disclose PHI about foreign military personnel to the appropriate foreign military authority.
12. **National Security and Intelligence Activities** - to authorized federal officials for the conduct of lawful intelligence, counterintelligence and other national security activities authorized by law.
13. **Protective Services for the President and Others** - to authorized federal officials: (i) for the provision of protective services to the President, other authorized persons or foreign heads of state; or (ii) for the conduct of authorized investigations.
14. **Inmates** - to a correctional institution or a law enforcement official who has lawful custody over you, as long as the disclosure is necessary: (i) for the institution to provide you with health care; (ii) to protect your health and safety or the health and safety of others; or (iii) for the safety and security of the correctional institution.
15. **Workers' Compensation** - to comply with workers' compensation laws and other similar legally established programs that provide benefits for work-related injuries or illnesses without regard to fault.
16. **Limited Data Set** - for purposes set forth in a valid data use agreement with the limited data set recipient, but only PHI that excludes certain direct identifiers, such as names and telephone numbers.
17. **Plan Sponsor** - to the trustees of the Plan, as the plan sponsor, for purposes related to plan administration if the Plan sponsor has amended its plan documents to protect your PHI as required by federal law.
18. **Individuals Involved in Your Care or Payment for Your Care** - to a friend, family member or other person identified by you who is involved in your medical care unless you notify the Plan that you object to or want to restrict the disclosure. The Plan may also disclose your PHI to a friend, family member or other person identified by you who assists in the payment of your medical care. It may also inform a family member, a personal representative or another person responsible for your care of your condition and/or your location. If a family member contacts the Plan on your behalf requesting PHI relating to your treatment or payment for

treatment, the Plan will, upon verification by requesting certain information from your family member (such as your Social Security number and date of birth) release such PHI to your family member unless you indicate to us in writing that you do not want family members to receive PHI from the Plan in those circumstances.

- 19. Incident to a Use and/or Disclosure Otherwise Permitted or Required** - incidentally during a permitted or required use or disclosure.

Other uses and/or disclosures of your PHI will be made only with your written authorization. With certain limited exceptions, the Plan must obtain an authorization for any use and/or disclosure of psychotherapy notes or for any use and/or disclosure of PHI for marketing purposes. Generally, you have the right to revoke any written authorization.

D. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- 1. Right of Access** - With certain limited exceptions, you have the right to inspect and copy your PHI contained in a "designated record set" that the Plan maintains. A designated record set is a group of records that include PHI and are maintained, collected, used, or distributed by or for the Plan that: (i) contains medical records and billing records about individuals; (ii) contains enrollment, payment, claims adjudication, and case or medical management record systems; or (iii) is used to make decisions about individuals. To exercise this right, you must submit your request in writing to the office of the Administrator of the DC 37 Health and Security Plan, 125 Barclay Street, 3rd Floor, New York, New York 10007, (212) 815-1300. The Plan may give you a summary of the PHI you requested instead of providing access to the PHI, or the Plan may give you an explanation of the PHI that it provides to you, if you agree to the summary or explanation and to any fees to be imposed for the summary or explanation. You must agree, orally or in writing, to these fees before the Plan can charge them to you. The Plan may charge a reasonable cost-based fee for the costs of copying, mailing or other supplies associated with your request. In certain instances, the Plan may deny your request to inspect and copy your PHI. If you are denied access, in some cases you may request that the denial be reviewed. In those cases, the Plan will designate a licensed health care professional (the "reviewer") to review your request and the denial. The reviewer will not be the same person who denied your first request. The Plan will take all actions necessary to carry out the reviewer's determination.
- 2. Right to Amend** - You have the right to request that the Plan amend your PHI for as long as the Plan maintains that information. You must submit a request for an amendment in writing to the office of the Administrator of the DC 37 Health and Security Plan, 125 Barclay Street, 3rd Floor, New York, New York 10007, (212) 815-1300. Also, you must provide a reason that supports your request. The Plan may deny your request for an amendment if it is not in writing or does not include a reason that supports the request. In addition, the Plan may deny your request if you ask the Plan to amend information that: (i) was not created by the Plan, unless the originator is no longer available to act on the requested amendment; (ii) is not part of the PHI kept by the Plan; (iii) is not part of the PHI which you would be permitted to inspect and copy; or (iv) already is accurate and complete.
- 3. Right to an Accounting of Disclosures** - You have the right to receive an accounting of the Plan's disclosures of your PHI for the past six years. However, this listing of disclosures will not include disclosures made (i) to carry out treatment, payment and/or health care operations, or (ii) with your authorization, or (iii) to you, or (iv) prior to April 14, 2003. You must submit your request for an accounting in writing to the office of the Administrator of the DC 37 Health and Security Plan, 125 Barclay Street, 3rd Floor, New York, New York 10007, (212) 815-1300. The first accounting the Plan gives to you within a 12-month period will be free. For each request for an accounting after the first one and during that same 12-month period, the Plan may impose a reasonable cost-based fee. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request before you incur any costs.
- 4. Right to Request Restrictions** - You have the right to request a restriction on the uses and/or disclosures of your PHI for treatment, payment and/or health care operations. You also have the right to request a restriction on the disclosure of your PHI to someone who is involved in your medical care or the payment of your medical care. The Plan is not required to agree to a restriction that you request. If the Plan does agree, it will comply with your request unless the PHI is needed for your treatment in an emergency. You must submit your request in writing to the office of the Administrator of the DC 37 Health and Security Plan, 125 Barclay Street, 3rd Floor, New York, New York 10007, (212) 815-1300.

5. **Right to Request Confidential Communications** - You have the right to request that you receive communications of your PHI from the Plan by alternative means or at alternative locations. You must submit your request in writing to the office of the Administrator of the DC 37 Health and Security Plan, 125 Barclay Street, 3rd Floor, New York, New York 10007, (212) 815-1300. Your request must contain a statement that disclosure of all or part of the information, by typical means or to your regular address, could endanger you. The Plan will accommodate all reasonable requests that provide sufficient evidence of endangerment. Your request must contain information regarding an alternative address or other method of contact.
6. **Right to a Paper Copy of This Notice** - You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at the following website, www.dc37.net. To obtain a paper copy of this notice contact the DC 37 Health and Security Plan Inquiry Unit, 125 Barclay Street, 3rd Floor, New York, New York 10007 at (212) 815-1531.

E. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("DHHS"). To file a complaint with the Plan, contact the DC 37 Health and Security Plan Inquiry Unit, 125 Barclay Street, 3rd Floor, New York, New York 10007, (212) 815-1234. To file a complaint with DHHS, mail your complaint to: Secretary of the U.S. Department Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. You must submit all complaints in writing. **The Plan will not retaliate against you for filing a complaint.**

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