BENEFIT BOOKLET

DOCTORS COUNCIL WELFARE FUND

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ACTUARIES AND CONSULTANTS

The Segal Company
333 West 34th Street
New York, New York 10001

Dear Member:

We are pleased to provide you with this updated benefit booklet summarizing benefits provided by the Doctors Council Welfare Fund. These benefits are provided at no cost to you and are funded through contributions made to the Fund by the City of New York, the New York City Health and Hospitals Corporation and the New York City Transit Authority under the Doctors Council collective bargaining agreement.

This booklet describes the features of your benefit plan. As you look through it, you will learn how you become a Fund member and what your benefits are. Since there have been changes in some of the benefits, please read this booklet carefully and show it to your family. It is important that they are aware of your benefits.

In preparing this booklet, we've done our best to explain everything correctly. This booklet will serve as the official plan document. If you have any questions about your benefits, the Fund Administrator will be pleased to help you.

The Fund Trustees reserve the right to change benefits as the need arises. Notice will be provided to members when benefits are amended. It is important that you read all communications sent to you by the Fund Office.

Sincerely,

Board of Trustees

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INTRODUCTION

In order to maximize your use of the listed benefits it is important that you and your dependents adhere to the following:

1) **File your benefit claims on time.** The Doctors Council Welfare Fund must receive the required documents postmarked no later than 1 Year from the date of service unless expressly provided otherwise for a particular benefit. If you believe that your claim will be late, contact the Fund office in writing before the one (1) year deadline has expired for further instructions;

2) Notify the Fund Office at once if there is a change in your family status. (See Changes in Family Status or Family Circumstance section);

3) Provide all information requested to prevent delay in processing your claim;

4) Review the description of benefits carefully, especially benefit exceptions and exclusions;

5) Read all information sent to you by the Fund office and respond to all requests in a timely fashion.

MEMBER ELIGIBILITY

This section includes the following:

- Eligibility Requirements
- Effective Coverage Date

Eligibility Requirements:

You are eligible for the benefits described in this booklet if you are in one of the following classifications:

- Full-Time Per Annum Doctor who is represented by Doctors Council for collective bargaining purposes and is employed by the City of New York and/or the New York City Health and Hospitals Corporation;
- Part-Time Per Annum Doctor who is represented by Doctors Council for collective bargaining purposes and is employed by the City of New York and/or the New York City Health and Hospitals Corporation; part-time per annum doctors who regularly work at least one-half the hours of a full-time employee in the same title are eligible for full-time benefits: part-time per annum doctors who regularly work less than one-half the hours of a full-time employee in the same title are eligible for part-time benefits;
- Per Session Doctor who works 375 hours or more each year, is represented by Doctors Council for collective bargaining purposes and is employed by the City of New York and/or the New York City Health and Hospitals Corporation; per session doctors employed by mayoral agencies at least one-half the hours of a full-time per annum employee are eligible for full-time benefits; all others are eligible for part-time benefits;
- Per Diem Doctor who works 375 hours or more each year, is represented by Doctors Council for collective bargaining purposes and is employed by the City of New York; Medical Investigators who complete 100 tours of duty in a calendar year and other per diem doctors who work at least one-half the hours of a full-time per annum employee are eligible for full-time benefit; all others are eligible for part-time benefits.
- Doctor in the Physician title who is employed by the New York City Transit Authority: Transit Authority doctors in the Physician title are eligible for *full-time benefits*.

Effective Coverage Date:

The date that your coverage begins depends upon your classification. If you are a full-time per annum doctor or a part-time per annum doctor, your coverage begins the first day you meet the above description.

If you are a per session or per diem doctor, your coverage begins on the first day of the month following the month in which you complete 375 hours of service in a Plan or Calendar Year, depending on your employer.

Per session and per diem doctors may be required to verify initial eligibility for benefits by submitting letters from their timekeepers stating the number of hours worked in the year to date. This will be necessary if contributions from your employer have not been received by the Fund at the time you submit your initial claim for benefits.

Per annum doctors may be required to submit letters from their personnel offices stating their title, status, and the date they began work. This will be necessary if contributions from your employer have not been received by the Fund at the time you submit your initial claim for benefits.

TERMINATION OF COVERAGE

For per annum employees, coverage ends when you leave employment with the City of New York, the New York City Health and Hospitals Corporation, or the New York City Transit Authority or are employed in a per annum capacity less than 17.5 hours per week. For per session employees, coverage ends when you leave covered employment or at the end of any Plan/Calendar year in which you work less than 375 hours, whichever is earlier. For per diem employees, coverage ends when you leave covered employment or at the end of the Plan/Calendar year in which you work less than 375 hours, whichever is earlier.

Dependent coverage continues for 30 days after the death of the member.

Please turn to the section of this booklet entitled "Self-Paid Continuation of Coverage (COBRA)" for details on how you can continue coverage for yourself and/or your dependents.

FAMILY/MEDICAL/MILITARY LEAVE

This section includes the following:

- Family and Medical Leave
- Military Leave

Family and Medical Leave:

If you are entitled by law to up to 12 weeks of unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care for spouses or domestic partner, child or parent who is ill, or for your own serious illness, you can continue your medical coverage during that leave period. Your employer is required to continue to pay your contributions for that coverage during the period of that leave. If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation of Coverage (see "Self-Paid Continuation of Coverage (COBRA)" section).

Questions regarding your entitlement to this leave should be referred to your employer. Questions about the continuation of your coverage should be referred to the Fund Office.

Military Leave:

If you go into active military service for up to 31 days, you can continue your medical coverage during such leave period. Your employer must continue to pay your contributions for coverage during such period of leave.

If you lose eligibility because of your induction into the Armed Forces, you will be reinstated for benefits as of the date of your re-employment with a contributing employer, provided that you secure such employment within 90 days of your discharge from the service or within 90 days of hospital discharge if you are hospitalized at the time of your separation from the service. If you are called into active military service for more than 31 days, you may be able to continue your coverage at your own expense for up to 18 months through COBRA.

Questions regarding your entitlement to this leave should be referred to your employer. Questions about the continuation of your coverage should be referred to the Fund Office.

BENEFIT COST

The benefits described in this booklet are provided without cost to you as the primary beneficiary. The City of New York, the New York City Health and Hospitals Corporation and the New York City Transit Authority pay the entire cost through contributions under the Doctors Council collective bargaining agreement. The contributions for these benefits do not come from payroll deductions. When your dependents cease to be eligible for benefits, you or they must contact the Fund Office for information about continuation of benefits on a self-paid basis (see COBRA section).

DEPENDENT COVERAGE

This section include the following:

- Dependent Eligibility
- Qualified Medical Child Support Order
- Extension of Dependent Coverage
- Changes in family status or family circumstance

Dependent Eligibility:

Your spouse or domestic partner and dependents up to the age of 19 (up to age 26 under the Affordable Care Act with completion of the Special Enrollment Form) are eligible for some of the benefits provided by this Fund. Reference to covered members' dependents means those spouses and children/grandchildren of the member who qualify as dependents under the Internal Revenue Code, and domestic partners determined by the Fund office to be eligible to receive domestic partner benefits from the Fund. Dependent children who, regardless of age, are unable to support themselves due to mental illness, developmental disability, mental retardation, or physical handicap, provided such incapacity occurred before age 19, are also considered eligible dependents by this Fund. See the description of each benefit for complete information.

A domestic partner is defined as a person, eighteen years of age or older, who is not married or related by blood to you in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with you and has been living with you on a continuous basis, and who, together with you, has registered with the City of New York as a domestic partner and has not terminated the domestic partnership. Members who are not eligible to register with the City of New York as a domestic partner because of their residency may satisfy the registration requirement by providing an Affidavit of Domestic Partnership, which must include a statement as to why they are not eligible to register with the City of New York**. In order to qualify for benefits, you must submit a copy of your registration certificate indicating the exact date you first registered or the Affidavit of Domestic Partnership.** Unless the domestic partner is also considered your dependent for tax purposes under Section 152 of the Internal Revenue Code, the Internal Revenue Service currently treats as imputed income to you the value of the benefits coverage provided to domestic partners. You are advised to review the consequences of electing this benefit with your own tax advisor.

In cases of multiple marriages/domestic partnerships when determining benefit annual or lifetime maximum, the Doctors Council Welfare Fund will consider the combined claims of an individual member's spouses/domestic partners as a single entitlement. For instance, if a member's former spouse/domestic partner reached the annual maximum limit on a benefit, the new spouse/domestic partner will not be entitled to that benefit until the next Plan Year. Likewise, if the member's former spouse reached the lifetime maximum on a benefit, then the new spouse/domestic partner will not be entitled to that benefit.

Qualified Medical Child Support Orders (QMCSO):

If a court or a state administrative agency has issued an order with respect to the provision of health care coverage for any of your dependent children, the Fund Administrator or its designee will determine if the court or state administrative agency order is a Qualified Medical Child Support Order (QMCSO) as defined by federal law, and that determination will be binding on the member. If the order is issued by a state administrative agency, the order must be issued through an administrative process established by state law and must have the force and effect of state law under the applicable state law.

An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not otherwise provide, except to the extent necessary to meet the requirements of the state's Medicaid-related child support laws.

If an order is determined to be a QMCSO, and if the member is covered by the Fund, the Fund Administrator or its designee will so notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage of the dependent children. However, no coverage will be provided for any dependent child under a QMCSO unless the applicable contributions for that dependent child's coverage are paid and all of the Fund's requirements for coverage of that dependent child have been satisfied.

Extension of Dependent Coverage:

Dependent coverage continues for 30 days without cost only after the death of the member. For coverage beyond 30 days after the death of the member and for coverage after divorce, or after legal separation, or when a dependent doesn't meet qualifications, see COBRA section.

Changes in family status or family circumstance:

- The Fund Office should be notified promptly when any change occurs in your family status such as: marriage, divorce, separation, termination/initiation of domestic partnership, birth or adoption of a child, death of the member, death of an eligible dependent or you wish to change the beneficiary of your life insurance benefit. The Fund must be notified within 30 days of the change.
- The member or eligible dependents should notify the Fund Office within 30 days from the date of any change of name and/or address.
- Dependent(s) for whom you have been formerly declined enrollment because of other health insurance coverage, you may enroll these dependent(s) in the plan within 30 days from the date the other insurance coverage ceases.
- The Fund should also be notified promptly of any change in employment status or leave of absence which may entitle you to continuation of coverage (see COBRA section).

COORDINATION OF BENEFITS

This section includes the following:

- Definition of Coordination of Benefits
- Determination of Benefit Payment
- Medicare
- Medicare and End Stage Renal Disease

Definition of Coordination of Benefits:

The Doctors Council Welfare Fund includes a coordination of benefits provision that determines which plan is primary and how benefits will be paid when you and/or your dependents are covered by more than one plan.

Coordination of benefits is a feature of many insurance programs. If you or your dependents are entitled to benefits under any other plan that would pay part or all of the expense incurred, the benefits payable under this plan and any other plans will be coordinated so that the aggregate amount of benefits paid will not exceed 100% of the expense incurred. In no event will the amount of benefits paid under this plan exceed the amount that would have been paid if there were no other plan involved.

You may be covered as a dependent under your spouse or domestic partner's plan in addition to being covered under this plan, or your dependents may be covered under both plans.

Determination of Benefit Payments:

The following order will determine which plan is the primary plan (i.e. the plan that pays first):

- The plan without a coordination of benefits provision.
- Where both plans have a coordination of benefits provision, the plan that covers a person as a member, rather than as a dependent.
- If you and your spouse or domestic partner are both covered as employees by the Doctors Council Welfare Fund, you will receive payment first as an employee and second as a dependent.
- In the case of a dependent child, the plan of the parent whose birthday occurs earlier in a calendar year pays first. If both parents have the same birthday, the plan which has covered the parent longer will pay first.

- If you are separated or divorced, there are special rules regarding coverage for your children. If a court order establishes responsibility for the health care expenses of your children, benefits are paid according to that order. If there is no court order, benefits are paid in the following order:
    1) The plan of the parent/stepparent having custody of the child.
    2) The plan of the parent/stepparent not having custody of the child.

Medicare:

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If you, your spouse or domestic partner and/or your dependent child are covered by this plan and by Medicare, as long as you remain actively employed, this plan pays first and Medicare pays second.

However, if you become entitled to Medicare because of your disability, you will no longer be considered to be actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this plan pays second (for the benefits that Medicare covers).

Medicare and End-Stage Renal Disease:

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this plan pays first and Medicare pays second for a limited period of time, 30 months. After this 30-month period, Medicare pays first and this Plan pays second.

Here's how coordination of benefits works in ESRD situations:

- Medicare generally imposes a three-month waiting period at the onset of end-stage renal disease before Medicare becomes effective. Therefore, this Plan would pay benefits during the waiting period and then continue to pay first for an additional 30 months, while Medicare pays second during the latter time period. Therefore, this plan will provide primary coverage for a total time period of 33 months. Beginning with the **34th month**, Medicare will pay first and this Plan will pay second.

- However, Medicare waives the waiting period if the patient enrolls in a self-dialysis training program or receives a kidney transplant within the first three months of diagnosis of ESRD. If the Medicare waiting period is waived, this plan will pay first for the first 30 months and Medicare will pay second. Beginning with the **31st month**, Medicare will pay first and this Plan will pay second.

CLAIM FILING PROCEDURES

This section includes the following:

- Claim Filing Procedure
- Claim Review

Claim Filing Procedure:

The procedure for filing claims depends on the benefit. Please see the explanation following each benefit for the correct procedure to follow. If you have not received Explanation of Benefit Statements from your other carriers in a timely fashion, you should contact the Fund Office **before** the One (1) year deadline for further instructions. **Claims submitted to the Fund postmarked more than One (1) Year from the date service was rendered will not be considered for payment.**

CLAIMS SENT TO THE WELFARE FUND MUST BE POSTMARKED NO LATER THAN ONE (1) YEAR FROM THE DATE SERVICE IS RENDERED, EXCEPT HEALTHCARE COST REIMBURSEMENT BENEFIT AND DISABILITY CLAIMS. FAILURE TO SUBMIT CLAIMS WITHIN THESE TIME DEADLINES WILL RESULT IN REJECTION OF THE CLAIM. THERE WILL BE NO PAYMENT BY THE WELFARE FUND ON LATE CLAIMS. MEMBERS HAVE A MAXIMUM OF TWO YEARS FROM THE DATE OF SERVICE TO SUBMIT VERIFICATION THAT THE CLAIMS WERE SUBMITTED TO THE MEMBER'S PRIMARY BENEFIT CARRIER

- Healthcare Cost Reimbursement Benefit Claims: **Must be postmarked no later than June 30th of the following Plan Year (July 1 - June 30).**
- Disability Claims (initial application): **Must be postmarked within three weeks of the onset of the disability**. Failure to file within this period will result in the extension of the member's unpaid waiting period, as explained further in the Disability Benefit section.
- Disability Claims (follow-up reports): The member must submit monthly follow-up reports to be completed by the member and his physician. Failure to file will result in non-payment.

- All Other Claims: **Claims submitted to the Welfare Fund must be postmarked no later than One (1) Year** from the date service is rendered. The penalty for the late submission of claims is non-payment.

Claim Review:

There is a claim review procedure to follow if your claim for a benefit is denied. See the "Claim Review Process" section for details.

BLOOD BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefit

Benefit Description:

Benefits are available to members and spouses or domestic partners. You are entitled to reimbursement for out-of-pocket expenses incurred for the replacement of blood not to exceed ten (10) units in any one period of hospitalization.

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office.

(a) Complete the claim form,

(b) Attach a copy of your hospital bill,

(c) Provide proof of out-of-pocket expenses,

(d) Return the claim form to the Fund Office with the required attachments postmarked within 1 Year from the date you were discharged from the hospital.

Claims submitted to the Welfare Fund postmarked more than One (1) Year from the date of your hospital discharge will not be considered for payment.

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefit provision, please see the Coordination of Benefit section.

COBRA REIMBURSEMENT BENEFIT

This section includes:

- Benefit Description
- Filing Procedure

Benefit Description:

Members in the Office of School Health and Oral Health of the New York City Department of Health and Mental Hygiene who are furloughed from their positions in the Summer are entitled to reimbursement every Plan Year (July 1-June 30) for up to three (3) months of COBRA payments for City health insurance in an amount not to exceed that which the City would pay for health insurance without any employee contribution. (This does not include the high-option rider for which the employee would pay the cost.) This benefit is effective June 1, 2007.

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the form and return it to the Fund Office with proof of payment of the COBRA premiums and a copy of the billing statement from the health insurance provider. **You must submit claim forms to the Fund Office postmarked within 1 Year after your last payment of COBRA premiums for that Summer. Claims submitted to the Welfare Fund postmarked more than One (1) Year after your last payment was made will not be considered for payment.**

DENTAL BENEFIT

This section includes the following:

- Benefit Description
- Filing a Claim
- Filing Deadline
- Choosing a Dentist
- Participating Dentist Program
- Using a Non-Participating Dentist
- Pre-treatment Plan
- Alternate Benefit Provision
- Non-covered Dental Services
- Implantology
- Dental Benefit Extension
- Coordination of Benefits
- Schedule of Dental Allowances

Benefit Description:

Dental benefits are available to members, spouses or domestic partners and eligible dependent children.

Maximum Benefit Per Person Each Plan Year (July 1 – June 30) is as follows:

Full-Time	$6,500
Part-time	$3,250

Maximum Benefit Per Family Each Plan Year (July 1 – June 30) is as follows.

Full-Time	$13,000
Part-Time	$6,500

Maximum Benefit Per Person per lifetime for Orthodontic Coverage is as follows:

Full-Time	$4,940 Maximum
Part-Time	$2,470 Maximum

Maximum Benefit Per Person per lifetime for Implants and Implant Related Services is as follows:

Full-Time	$5,000
Part-Time	$2,500

All dental reimbursement is in accordance with the fee schedule.

Filing a claim:

Obtain claim forms from the Fund Office. Return completed claim forms to:

Self-Insured Dental Services
303 Merrick Road
PO Box 9005
Lynbrook, New York 11563-9005
(718) 204-7172
(516) 396-5500
(800) 537-1238
(516) 872-1295 (FAX)
www.asonet.com

All inquiries with respect to the status of your dental claim may be addressed to the dental administrator Self-Insured Dental Services.

Filing Deadline:

All dental claims must be postmarked no later than One (1) Year from the date service was rendered.

Choosing a Dentist:

Treatment may be provided by a dentist in the Doctors Council Welfare Fund Participating Dentist Program or by any other licensed dentist you choose.

Participating Dentist Program:

The Participating Dentist Program is designed to provide you with comprehensive dental care services while reducing or eliminating your out-of-pocket expenses. Participating dentists will accept the amounts shown in the Schedule of Dental Allowances as payment in full for services that are listed in the Schedule of Dental Allowances with the following exceptions:

- For services listed in the Schedule for which the Fund will not pay due to plan limitations and exclusions or where frequency limitations and plan maximums are exceeded.
- For services rendered by a non-participating provider, such as an Anesthesiologist, in conjunction with, or as part of, the treatment or services rendered by the participating dentist.
- For non-covered services, i.e., services not listed in this booklet and/or indicated under non-covered services in this section. If a dental service is performed for a condition that is not listed in the Schedule, but alternative treatments are listed, your dental Plan may pay a benefit based on the listed service that would produce a professionally satisfactory result.

Since usual and customary dental charges generally exceed the dental plan allowances listed in the Schedule of Dental Allowances, using a participating dentist for treatment will represent an overall savings to you in the cost of your dental services.

It is important to understand that the Fund and its dental administrator, S.I.D.S., do not recommend any particular dentist. You are responsible to select the dentist of your choice and should exercise the same care, and apply the same criteria, in selecting a participating dentist as you would in selecting a non-participating dentist.

To take advantage of the Participating Dentist Program, select a dentist from the list of participating dentists available from the Fund Office, and call for an appointment. Be sure to identify yourself as a member of the Doctors Council Welfare Fund and confirm that the dentist is a Doctors Council Participating Dentist.

When you receive treatment from a dentist in the Participating Dentist Program, you will be expected to assign benefits by signing the appropriate space on the claim form so that the participating dentist can be paid directly by the Doctors Council Welfare Fund.

<u>Using a non-Participating Dentist:</u>

If you choose to seek treatment from a non-participating dentist, the Fund will reimburse you up to the maximum allowance set forth in the Schedule of Dental Allowances in accordance with the plan's limitations and exclusions (see non-covered services in this section). If the non-participating dentist charges less than the Schedule allows, you will be reimbursed for the actual amount of your bill. If

your dentist charges more than the schedule allows, you will be reimbursed for the scheduled amount and you will be responsible for the balance of the charge yourself.

When you receive treatment from a non-participating dentist, the Doctors Council Welfare Fund does not assign benefits — that is, payment is made to the member only.

Pre-treatment plan:

The Fund recommends that you submit a pre-treatment plan to the Fund's dental administrator prior to the commencement of your dental work if your dental work will

- Involve charges for $300 or more in a 90-day period,
- Involve prosthodontics (dentures/crowns/bridges) or gold, acrylic, or porcelain crowns or jackets or laminates regardless of the charge,
- Involve periodontal surgery,
- Involve Orthodontia

The process is intended to inform the patient and dentist, in advance of treatment, what benefits are provided by the dental program. It enables you to obtain a determination by the Fund of what it will pay for the service prior to undertaking treatment and incurring expenses.

A Pre-Treatment Plan is a statement from your dentist that includes:

- An itemized list of recommended procedures,
- The charges for each procedure, and
- Supporting documentation, such as X-rays, photographs, charting, narrative.

S.I.D.S. will review the proposed treatment and apply the appropriate plan provisions. You and your dentist will receive a report showing the amount the Fund will pay for each procedure. If there are disallowances, these will also be indicated along with an explanation for the disallowances. Discuss the treatment plan and the benefits payable with your dentist.

If you receive a pre-treatment authorization for a proposed course of treatment that was submitted by one dentist, that pre-authorization will remain valid if you elect to have some or all of the work done by another dentist. The pre-authorization will be honored for one year after issuance.

Please be aware that a pre-treatment authorization is not a promise of payment. Work must be done while you are still covered by the Fund for benefits (except where there is an Extension of Benefits as described above) and no significant change can have occurred in the condition of your mouth after the pre-estimate was issued. Payment will be made in accordance with plan allowances and limitations in effect at the time services are provided and prior to the work.

IN ORDER TO ENSURE YOUR ELIGIBILITY FOR REIMBURSEMENT, YOU MUST SUBMIT A PRE-TREATMENT PLAN PRIOR TO THE COMMENCEMENT OF THE WORK.

If this procedure is not followed, the Fund's dental administrator will determine what benefits, if any, are payable. The dental administrator will take into consideration alternative courses of treatment, and if the benefit determined by the dental administrator is less than your total bill, you will be responsible for the difference.

Alternate Benefit Provision:

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could provide a suitable result based on commonly accepted dental standards. In these instances, the Fund will determine the Alternate Course of Treatment on which payment will be based and the expenses that will be included as Covered Expenses. You may elect to follow the original course of treatment and be responsible for charges which exceed Plan allowances for the Alternate Treatment.

Non-covered dental services:

The Dental Plan provides no coverage or reimbursement for the following:

- Procedures performed by a patient's immediate family (mother, father, son, daughter, spouse, domestic partner, brother or sister) with the exception that coverage will be provided for fees for laboratory services related to fixed and removable prostheses, which would include full dentures, partial dentures, crowns, bridges, castings, inlays and bite plates,
- Procedures or supplies not listed in the dental schedule,
- Services and supplies not furnished by a dentist, except X-rays ordered by a dentist and the services of a licensed dental hygienist performed under a dentist's supervision;

- Services provided by the U.S. government or any other government, for which payment is not required of the member;
- Surgical and prosthetic aspects of implants except as noted in the Schedule of Dental Allowances. Payment will be made only for conventional restoration of the mouth;
- Services resulting from an automobile accident covered by No-Fault insurance;
- Services caused by war or an act of war or while serving in the military;
- Cosmetic services unless made necessary because of an accident while the member is covered;
- Services resulting from a work-related accident or disease covered by Workers' Compensation;
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the tempromandibular joint;
- Multiple bridge abutments.

Implantology:

Payment for a prosthetic device attached to a surgical implant will be based on a course of treatment that would be appropriate if no implant was placed.

The lifetime maximum for implants is $5,000 per patient.

For purposes of benefit determination, an implant will not be considered to have replaced a natural tooth, and only remaining natural teeth will be considered as potential abutment teeth on which a prosthetic device will be constructed. For example, in applying the alternate benefit provision, when a claim is submitted for fixed bridgework to replace missing teeth, surgical implants will not be considered as possible abutments for the fixed bridge. Benefit determination will be based on allowances for the course of treatment that would be covered if no implant was placed.

As an exception, payment may be made for a crown on an implant in instances where only one natural tooth is missing in a jaw, and the prognosis for all the remaining natural teeth is good.

Dental Benefit Extension:

The Dental Plan has a provision for extension of your benefits in the event your coverage in the Fund ceases. Coverage for certain dental services commenced or approved prior to termination of your general eligibility for Fund benefits will continue for 30 days after the date your other coverage ends. The extensions are detailed below.

Benefits are extended for:

- work authorized prior to termination of your general eligibility for Fund benefits;
- an appliance or modification of an appliance for which a final impression was taken before termination;
- a crown, bridge or gold restoration for which a tooth or teeth were prepared before termination;
- root canal therapy, if the pulp chamber was opened before termination.

For dental benefit extension beyond 30-days see COBRA Extension section.

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefits provision, please see Determination of Benefits section.

SCHEDULE OF DENTAL ALLOWANCES

Self-insured Dental Services / Administrative Services Only, Inc Dental Plan Administrator

DOCTORS COUNCIL WELFARE FUND **Effective January 1, 2010**

Active & Retired Members – 100% of Schedule Allowance
Sessional & Part-Time Members – 50% of Schedule Allowance

DIAGNOSTIC & PREVENTIVE	Scheduled Allowance
ORAL EXAM	60.00
FULL MOUTH SERIES	140.00
PANORAMIC X-RAY	120.00
PA or BW X-RAY	14.00
OCCLUSAL FILM	50.00
EXTRA ORAL or TMJ FILM	34.00
CEPHALOMETRIC FILM	85.00
PROPHYLAXIS – ADULT	85.00
PROPHYLAXIS – CHILD	70.00
SPACE MAINTAINER – ACRYLIC	101.00
SPACE MAINTAINER – METAL	250.00
FLUROIDE	35.00
SEALANT	35.00
DIAGNOSTIC CASTS	50.00
RESTORATIVE	
SILVER AMALGAMS	
One surface	95.00
Two surface	135.00
Three surfaces	150.00
Four or more surface	190.00
PLASTIC or SILICATE FILL	30.00
COMPOSITE RESIN - 1srf anterior	110.00
COMPOSITE RESIN - 2srf anterior	135.00
COMPOSITE RESIN - 3 or more surfaces anterior	160.00
RESIN – INCISALANGLE	190.00
COMPOSITE RESIN - 1srf posterior	115.00
COMPOSITE RESIN - 2srf posterior	150.00
COMPOSITE RESIN - 3srf posterior	185.00
COMPOSITE RESIN - 4srf posterior	240.00
PIN RETENTION	25.00
METALLIC INLAY - 1srf	150.00
METALLIC INLAY - 2srf	400.00
METALLIC INLAY - 3srf	750.00
PORCELAIN INLAY - 1srf	168.00
PORCELAIN INLAY - 2srf	400.00
PORCELAIN INLAY – 3srf	750.00
COMPOSITE INLAY – 1srf	95.00
COMPOSITE INLAY – 2srf	125.00
COMPOSITE INLAY – 3srf	300.00
CAST POST & CORE	300.00
PER-FAB POST & CORE	175.00
LAMINATE VENEER – LAB	500.00
CROWNS & BRIDGES	
CROWNS	
Acrylic jacket (lab)	193.00
Stainless steel (primary tth)	67.00
Porcelain jacket	800.00
Plastic with metal	575.00
Porcelain with metal	800.00
Full cast	750.00
¾ cast	600.00
RECEMENTATION	
Of crown	60.00
Of Inlay	50.00
Of bridge	85.00
ENDODONTICS	
PULP DIRECT – direct	50.00
PULP CAP – indirect	35.00
VITAL PULPOTOMY	125.00
ROOT THERAPY	
One canal	500.00
Two canals	700.00
Three canals	850.00
APICOECTOMY – 1ST root	400.00
APICOECTOMY – maximum per tooth	800.00
RETROGRADE ROOT FILL – per root	125.00
ROOT RESECTION	175.00
ROOT THERAPY – RETREATMENT	
One canal	800.00
Two canals	900.00
Three canals	950.00

PERIODONTICS	Scheduled Allowance
PERIODONTAL TREATMENT	
Root scaling, subgingival curettage, bite correction, including proph	
Per quad	70.00
Maximum pre visit	140.00
OCCLUSAL ADJUSTMENT – COMPLETE	80.00
PERIODONTAL SURGERY	
Gingivectomy or gingivoplasty, delivery of	
Chemotherapeutic agents, soft tissue graft	
Vestibuloplasty, any combination, per quad	175.00
OSSESOUS SURGERY	600.00
OSSESOUS GRAFT - SINGLE SITE	150.00
GUIDED TISSUE REGENERATION	275.00
FREE SOFT TISSUE GRAFTS – PER QUAD	450.00
LOCALIZED DELIV OF CHEMO AGENT – Per Site	50.00
PERIODONTAL MAINENANCE	100.00
ORAL SURGERY	
ROUTINE EXTRACTION	125.00
SURGICAL EXTRACTION	
Erupted tooth	225.00
Impaction – soft tissue	200.00
Impaction – partial bony	325.00
Impaction – complete bony	450.00
CYST REMOVAL	200.00
ALVEOLOPLASTY – per quad	200.00
INCISION AND DRAINAGE	125.00
DENTURES	
COMPLETE DENTURE	
Immediate or permanent	800.00
PARTIAL ACRYLIC BASE	550.00
UNILATERAL – one tooth	500.00
PARTIAL – CAST METAL BASE	800.00
TISSUE CONDITIONING	70.00
PRECISION ATTACHMENT	325.00
DENTURE REPAIRS	
Broken denture base	95.00
Replace tooth in denture	95.00
Replace broken facing	95.00
Add or replace clasp	125.00
Reattach clasp	65.00
Add tooth to existing partial	125.00
DENTURE ADJUSTMENT	50.00
DENTURE RELINE	
Partial – office	135.00
Complete – office	165.00
Partial lab	175.00
Complete lab	300.00
BRIDGE PONTICS	
Full cast	500.00
Plastic with metal	560.00
Porcelain with metal	685.00
ENDOSSEOUS IMPLANT	1400.00
SUBPERIOSTEAL IMPLANT	1400.00
CROWN OVER IMPLANT	900.00
ABUTMENTS	
Inlay – 2 surface	400.00
Inlay – 3 surface	500.00
Plastic with metal	550.00
Porcelain with metal	775.00
Full cast	500.00
¾ cast	525.00
Maryland bridge retainer	250.00
Custom Abutment	500.00
ORTHODONTICS	
DIAGNOSIS & INTIAL INSERTION	1250.00
ACTIVE TX – per mouth, maximum 24 months	120.00
POST-TREATMENT STABILIZATION DEVICE	225.00
PASSIVE TX – per 3 months, maximum 9 months	120.00
ADJUNCTIVE SERVICES	
GENERAL ANESTHESIA/ IV SEDATION	250.00
CONSULTATION	85.00
PALLIATIVE TREATMENT	45.00
ANALGESIA	50.00
APPLICATION OF DESENSITIZING AGENT	20.00
BRUXISM APPLIANCE	300.00

REV. 3/11

DISABILITY BENEFIT

This section includes the following:

- Benefit Description
- Payment Period
- Exclusions
- Claim Filing Procedure
- Follow-Up Report

Benefit Description:

Members are eligible to receive monthly income for a period of up to thirty-six (36) months if they are TOTALLY DISABLED as the result of an illness or injury. Total disability means that you are under the regular care of a licensed physician and that you are TOTALLY UNABLE TO PERFORM THE DUTIES OF YOUR PROFESSION. This benefit is not available to your spouse, domestic partners or other dependents.

If you are eligible for Full-Time benefits, your gross monthly disability benefit is $2,000.00.
If you are eligible for Part-Time benefits, your gross monthly disability benefit is $1000.00.

This amount is in addition to disability benefits you may be eligible for through Social Security or private insurance.

Benefits are provided for a maximum of thirty six (36) months.

You do not receive benefits for the ten-week waiting period.

Members receiving Workers Compensation or No Fault benefits may not receive a benefit in excess of their regular salaries through the combined benefits received from the Fund and the other payer.

Payment Period:

Benefits under this Plan begin the first day following a ten-week waiting period (after you have been TOTALLY DISABLED for ten (10) consecutive weeks). Successive disability periods separated by less than ten (10) weeks of continuous active employment in your profession are considered one continuous period of disability unless they arise from different and unrelated causes.

Benefits cease on your effective date of retirement if you receive New York City retirement benefits, after thirty six (36) months of disability payments, or when you are no longer disabled as defined above, whichever occurs first.

Exclusions:

All disabilities are covered under this Plan unless they are the result of:

- war, including undeclared war and armed aggression,
- intentionally self-inflicted injury or attempted suicide,
- imprisonment for a criminal or other offense,

Claim Filing Procedure:

Initial Application:

If you are totally unable to perform the duties of your profession and are under a doctor's care, you and your doctor must complete and submit claim forms which are available from the Fund Office describing your disability. Both the member's and the physician's claim forms must be postmarked **WITHIN THREE WEEKS** of the onset of the disability. Failure to file within this period will result in the extension of the member's unpaid waiting period by the additional time between the three-week filing deadline and the actual time of filing the claim. (For example: if the onset of the disability was January 1, and the claim was filed February 15, twenty-four days of non-payment of benefits would be added onto the ten week waiting period extending the member's period of non-payment to thirteen weeks and three days.) **You or your physician must submit the physician's disability claim form and detailed medical records with supporting documentation of your disability within the three-week period for the application to be timely.**

Follow-Up Report:

If, after having received our initial benefit payment from the Fund, the disability continues, the member must submit monthly follow-up reports to be completed by the member and his/her physician. Failure to file will result in non-payment.

THE FUND RESERVES THE RIGHT TO OBTAIN AN INDEPENDENT MEDICAL EXAMINATION AND APPROPRIATE TEST RESULTS. FAILURE TO TAKE THIS EXAMINATION WHEN REQUESTED, OR FAILURE TO BE EXAMINED IN A TIMELY FASHION MAY RESULT IN DENIAL OF YOUR CLAIM. IF YOUR CLAIM IS APPROVED, THE FUND RESERVES THE RIGHT TO OBTAIN SUBSEQUENT INDEPENDENT MEDICAL EXAMINATIONS AND TEST RESULTS TO VERIFY THE CONTINUING NATURE OF THE DISABILITY.

HEALTHCARE COST REIMBURSEMENT BENEFIT

This section includes:

- Benefit Description
- Covered Services
- Filing Procedure

Benefit Description:

Member, spouse or domestic partners and eligible dependent children are entitled to reimbursement expense every Plan Year (July 1 - June 30).

Full-time - **$1,000** per family

Part-time - **$500** per family

Covered Services:

The following services are covered:

1) medical and hospital deductibles and co-payments under Medicare and/or your group medical/surgical and hospital insurers;
2) prescription drug deductibles or co-payments under your group medical/surgical and hospital insurers;
3) charges incurred for health services covered in a member's, or participant's, existing coverage that exceed the reimbursement received, including services covered under Doctors Council Retiree Welfare Fund;
4) premiums for Medicare Part "B", Medigap, and other out-of-pocket healthcare expense

Filing procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the claim form and attach all copies of Explanation of Benefits Statements and itemized bills. **Do not submit your claim until the end of the Plan year unless you have already met the full amount of the benefit. All claims for benefits for the Plan Year ending June 30 must be postmarked no later than June 30 of the following Plan Year (July 1 - June 30).**

HEARING AID BENEFIT

This section includes the following:

- Benefit Description
- Covered Expenses
- Exclusions
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Under this benefit, a member and spouse or domestic partner and eligible dependents and dependent children are eligible for reimbursement once every two years for the purchase, repair and maintenance of hearing aids (batteries are not included) and for a hearing examination not covered by Medicare or any other insurance.

Full-Time	$1,500 Member/Spouse/Domestic Partner/Children Per Person
Part-Time	$750 Member/Spouse/Domestic Partner/Children Per Person

Hearing aids are available for both ears if prescribed.

Covered Expenses:

- cost of installation or repair of a hearing aid that was provided subsequent to the date of a written recommendation by an Otologist or Otolaryngologist or Licensed Audiologist.
- cost of a hearing examination by an Otologist or Otolaryngologist or Licensed Audiologist if it is given with the intent or purpose of prescribing a hearing aid.

Exclusions:

- a hearing aid not recommended by an Otologist or Otolaryngologist physician or Licensed Audiologist
- expenses for which benefits are payable under any Workers' Compensation Law;
- benefits payable under Medicare or any other governmental plan;
- charges for services or supplies which are covered in whole or in part under any other plan;
- procedures performed by immediate family members.

Filing Procedure:

Obtain a claim form from the Fund Office. Take this form with you when you go for an appointment. Complete the member's portion and have your Practitioner or Licensed Audiologist complete the physician's portion. Attach the itemized bill for the hearing aid to this form, and return it to the Fund Office postmarked within 1 Year from the date the services were rendered. **Claims postmarked more than 1 Year from the date the services were rendered will not be considered for payment.** The bill must be itemized and describe the appliance purchased, the amount charged, the name of the person who required the hearing appliance, and must include or be supplemented by the Otologist's or Otolaryngologist's or Licensed Audiologist's authorization or certification for the appliance.

The hearing examination must be performed and the certification completed and signed by an Otologist/ Otolaryngologist or Licensed Audiologist. **The Welfare Fund will not honor the claim if the member or spouse has had the services rendered by a Practitioner other than an Otologist/ Otolaryngologist or Licensed Audiologist.**

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefit provision, please see "Determination of Benefits" section.

LEGAL SERVICES BENEFIT

New York State Residents

This section includes the following:

- Benefit Description
- Exclusions
- Filing Procedure

Benefit Description:

The legal services covered by the Fund are limited to those which can be provided by lawyers admitted to practice in the state of New York. The law firm of Pryor Cashman LLP, 7 Times Square, New York, New York 10036 has been retained for the purpose of providing the legal services benefit, and all matters will be handled confidentially on an attorney-client basis. Each covered doctor is responsible for reimbursing the law firm directly for expenses (e.g., toll calls, photocopies, transportation, filing fees, etc.) for services performed on behalf of the doctor or his/her spouse or domestic partner. No expense over **$75** will be incurred without the doctor's prior knowledge and approval. The law firm will require payment of an advance against disbursements for expenses and legal fees of up to **$7,000** for all matters.

Legal services will be available at the fees indicated hereafter to covered doctors and, where specifically indicated, their spouse or domestic partner for the following matters:

REAL ESTATE: The purchase, sale or financing of a private or two-family residence owned by a covered doctor individually or jointly with another family member and used as the member's primary residence is covered at a fee of **$425**; in the event of a second purchase, sale or financing within two years of the closing of the first transaction under the Plan, a fee of **$800** will be payable; for a third or subsequent transaction within two years of the closing of the first transaction under the Plan, a fee of **$1,150** will be payable. For example, a member selling one residence and purchasing another any time within two years of the closing of sale would pay a fee of **$425** for the first transaction and **$800** for the second transaction.

MATRIMONIAL: An uncontested divorce involving a covered doctor for a fixed fee of **$500**;

ADOPTION: An uncontested adoption, where a covered doctor is an adoptive parent for a fixed fee of **$500**;

NAME CHANGE: A change of name of a covered doctor, spouse/domestic partner or dependent for a fixed fee of **$500**;

CRIMINAL DEFENSE: Defense in a criminal prosecution, up to and through the point of arraignment, for a covered doctor, spouse or domestic partner for a fixed fee of **$500**;

GENERAL CONSULTATION/ REPRESENTATION: In each plan year, two hours of general consultation (without charge to the participant) or other legal services on behalf of a covered doctor, spouse or domestic partner concerning any legal matter (without charge to the participant), except those covered under the Plan on a contributory basis or excluded below, and up to fifty (50) additional hours at a reduced hourly rate of **$180** (payable by the covered doctor);

ESTATE ADMINISTRATION: In each plan year, probate of an uncontested estate of a member or his/her spouse or domestic partner, parents, children or grandparents, and/or the processing of a claim pertaining to an estate on behalf of a covered doctor and/or spouse or domestic partner, including five (5) hours of service without charge to the member and up to twenty-five (25) additional hours at a reduced hourly rate of **$180** (payable by the covered doctor);

ESTATE PLANNING: Drafting and settlement of a will or codicil (any amendment to a will) for a covered doctor, spouse or domestic partner at a single charge of **$450** to the doctor; a **$800** fee covers services for both the eligible doctor and spouse or domestic partner, provided that the estate planning and

preparation and execution of the wills are undertaken concurrently; in the case of complex estate planning, documents (other than the will or codicil. Power of attorney and health care proxy) such as an insurance trust, inter vivos trust or a real estate transfer related to estate planning will be prepared for an additional charge of **$300** per document.

PERSONAL INJURY: Personal injury and property damage actions on behalf of a covered doctor and his/her dependents at a contingency fee of 25% of any recovery; the legal service provider reserves the right to reject proceeding on a contingency fee basis.

Exclusions:

The following matters are not covered under this Plan:

- Matters involving controversy or a conflict with the City of New York, the New York City Health and Hospitals Corporation, or the New York City Transit Authority, or otherwise arising out of your employment under a Doctors Council contract, except for a proceeding initiated by a State administrative agency which may result in the suspension or revocation of a member's license; and
- Legal services required in any matter not specifically stated above over fifty (50) hours. Upon the exhaustion of fifty (50) hours of legal services, the member may, at his or her option, retain the firm at its regular rates or obtain other counsel.

Filing Procedure:

You must call the Fund Office directly at (212) 532-7690. The Fund Office will then determine whether you are a covered doctor and advise the law firm accordingly or send you the appropriate reimbursement forms if you participate in the out-of-state LSP. If you participate in the In-state LSP the Welfare Fund employee will not ask you about the nature of the matter.

Do not call the lawyer's office. They can provide no services until they receive certification from the Fund Office indicating that you are covered.

LEGAL SERVICE BENEFIT

Out-of-State Residents

This section includes the following:

- Benefit Description
- Filing Procedure
- Filing Deadline

Benefit Description:

Members who reside outside of the State of New York will be enrolled in the Out-of-State Legal Services Plan unless they express their wishes in writing to join the In-State Legal Services Plan. In order to choose the In-State LSP, a member must notify the Fund Office prior to the beginning of the new fiscal year (July 1) that he/she wishes to be a participant in the In-State LSP for the coming year, and until further notice.

The out-of-state LSP provides up to **$600** reimbursement for fees paid for either the preparation of a will for member or spouse/domestic partner OR a real estate closing (restricted to personal residence of member or spouse/domestic partner) or the refinancing of a mortgage once each Plan Year (July 1 - June 30).

MEMBERS OF THE OUT-OF-STATE LSP ARE NOT ENTITLED TO THE SERVICES OF THE IN-STATE LSP

Filing Procedure:

You must call the Fund Office directly at (212) 532-7690. The Fund Office will then determine whether you are a covered member and send the appropriate reimbursement forms if you participate in the out-of-state LSP.

Filing Deadline:

Claims postmarked more than One (1) Year after the date of service is rendered will not be considered for payment.

LIFE INSURANCE BENEFIT

This section includes the following:

- Benefit Description
- Beneficiary(ies)
- Conversion to Individual Policy
- Payment of Benefit

Benefit Description:

Your term life insurance coverage is provided through the Prudential Life Insurance Company of America. This coverage is only available to the member.

Age	Full-Time	Part-Time
Up to 65	$50,000	$25,000
66	45,000	22,500
67	40,000	20,000
68	35,000	17,500
69	30,000	15,000
70 - 74	17,500	8,750
75 - 79	15,000	7,500
80 - 84	10,000	5,000
85	7,500	3,750

Beneficiary(ies):

Your life insurance will be paid to any beneficiary(ies) you name if you die while you are insured. If no beneficiary(ies) is/are designated, payment will be made to your estate. You must complete an enrollment card to designate your beneficiary(ies). Enrollment and designation of beneficiary forms are available at the Fund Office. You may change your beneficiary(ies) at any time. Changes must be filed at the Fund Office.

Conversion to Individual Policy:

If you are no longer eligible for participation in the Fund as described on pages 2 and 3, your life insurance coverage terminates. When this happens, notify the Fund Office immediately. If you fail to notify the Fund Office when you leave the payroll, you may lose the right to convert. You have 31 days after your insurance terminates to convert by filing the appropriate forms, which are available at the Fund Office. You can convert your group life insurance coverage to an individual policy without a medical examination. When the conversion application has been timely filed with the insurer, a policy will be issued at the insurance company's regular rates based on your age and sex.

If you do not convert to an individual policy, your coverage will end 31 days after your separation from employment. If you die during this 31-day period, your beneficiary will receive the full amount of your group life insurance coverage.

Payment of Benefit:

Your beneficiary must notify the Fund Office and provide a certified copy of the death certificate. The Fund Office will assist your beneficiary in filing the claim with the insurance company.

MAMMOGRAPHY BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Benefits are available to members, spouses and domestic partners per Plan Year (July 1 – June 30) at the following levels:

Full-Time	$200
Part-Time	$200

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the form and return it to the Fund Office with a copy of your itemized receipt. **You must submit claim forms to the Fund Office postmarked within One (1) Year after service was rendered. Claims submitted to the Welfare Fund postmarked more than One (1) Year after service was rendered will not be considered for payment**.

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefits provision, please see "Determination of Benefits" section.

MATERNITY/ADOPTION BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure

Benefit Description:

Benefits are available to members, spouses or domestic partners for a birth or adoption of a member's child at the following levels:

Full-Time	$2,000 per claim
Part-Time	$1,000 per claim

Limited to one claim per Plan Year (July 1-June 30)

Member's name must appear on birth/adoption certificate.

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the form and return it to the Fund Office with a copy of the birth certificate. **Claims submitted to the Welfare Fund postmarked more than One (1) Year after delivery/date on the adoption certificate will not be considered for payment.**

OPTICAL BENEFIT

This section includes the following:

- Benefit Description
- Exclusions
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Member, spouse or domestic partner and eligible dependent children are each entitled to reimbursement once every Plan Year (July 1 – June 30) for prescription eyeglasses, contact lenses and eye examinations. In addition, Lasik surgery procedures will be reimbursed up to a lifetime maximum of $500 **or** (b) obtain services from the PPO network of optical providers through CPS Optical; you can elect **only one form of benefit** each Plan year.

Optical PPO Network Through CPS Optical

A network of participating providers of optical benefits is available to members, spouses/domestic partners and eligible dependents. Under this option, specific benefits and products are provided at NO COST or at a reduced cost, depending on your status and/or selection of services and products. **Electing this option requires a PRE-CERTIFICATION VOUCHER from the Fund Office PRIOR to visiting the provider.** Contact the Fund Office for a current list of participating providers.

Full-Time	$300.00 per person
Part-Time	$150.00 per person

Exclusions:

Exclusions under this benefit are:

- Expenses for which benefits are payable under any Workers' Compensation Law,
- Expenses for which benefits are payable under Medicare or any governmental plan,
- Medical or surgical treatment of the eye or eyes,
- Charges for services or supplies which are covered in whole or in part under any other plan,
- Charges for services provided by an immediate family member except for out-of-pocket expenses relating to materials and laboratory expenses at cost,
- Services provided by an individual who is not a licensed dispenser of these services.

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the claim form and attach a copy of your itemized receipt and return the claim form to the Fund Office **postmarked within One (1) Year** from the date service was completed. **Claims postmarked more than One (1) Year from the date service was completed will not be considered for payment**.

Coordination of Benefits:

If reimbursement is sought for an eye examination only, you must also submit a copy of your rejection or payment voucher from your other health insurer.

For a complete description of your coordination of benefits provision, please see "Determination of Benefits" section.

PHYSICAL EXAMINATIONS

Benefit Description:

Members, spouses and domestic partners are covered once a year for a physical examination which includes laboratory tests. The examination will be provided by Affiliated Physicians at their office located at 255 Greenwich Street, Suite 520, NY, New York 10007.

The examinations and consultations are completely private and strictly confidential. After all tests have been evaluated, a full report will be sent to you or your personal physician if you desire.

Obtain certification from the Fund Office to make an appointment for the physical exam. Do not call Affiliated Physicians. They can provide no service until they receive certification from the Fund Office indicating that you are covered.

A $100 no-show fee is assessable to the member if an appointment is not cancelled 48 hours before the confirmed time.

If an appointment is scheduled at an out-of-town facility, there will be a $235 co-payment for the basic exam which the patient is responsible to pay at the time of appointment.

The exam will include all of the following:

Complete Personal and Family History
Physical Examination Of All Body Systems
X-ray of the Heart and Lungs
12 Lead Resting Electrocardiogram with complete interpretation
Audiometric screening (500, 1000, 2000, 3000, 4000, 6000 CPS)
Eye Tests by Ortho-rater
Near and Distant Vision
Color Vision
Tonometry for Glaucoma
Thyroid Function Test
Pap smear

PSA

Complete pulmonary function analysis

Stool test for occult blood (3 slides)

SMAC blood chemistry analysis

BUN (Blood Urea Nitrogen)	Phosphorus	Bilirubin (total)
Glucose	Cholesterol	Potassium
Creatinine	Triglycerides	Chloride
Uric Acid	Calcium	Carbon Dioxide
Total Protein	Alkaline Phosphatase	Sodium
Albumin	SGOT	
Globulin	SGPT	
A/G Ratio	LDH (Lactic Dehydrogenase)	

Cholesterol Fractionation, for coronary risk evaluation:

HDL (High Density Lipoprotein)

LDL (Low Density Lipoprotein)

Hematology:	Red Blood Count		Hemoglobin
	White Blood Count		Hematocrit
	Differential Screening		Platelets
Urinalysis:	Glucose (Sugar)	RBC	Bile
Albumin	WBC	Acetone	
Ph Reaction	Color	Occult Blood	
Protein	Appearance	Specific Gravity	

In addition, the following procedures are covered by the Fund when medically indicated:

Bone Densitometer (on site)

Cardiac Stress Test

Mammography

PODIATRY BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefits
- Schedule of Allowances

Benefit Description:

Under this benefit member, spouse or domestic partner are reimbursed for visits to a podiatrist, up to a maximum of 15 visits per individual per Plan Year (July 1- June 30), according to the schedule of allowances listed below.

Maximum Allowance per Plan Year = $5,000.00

Orthotic Appliances (impression of the feet and construction of the appliance) that have been prescribed by a Podiatrist are subject to a maximum per Plan Year of $450.00 for full-time members and $225.00 for part-time members.

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the form and return it to the Fund Office with a copy of your bill and the reimbursement statement from your other insurance carriers within 1 Year from the date service was rendered. **Claims submitted to the Welfare Fund, postmarked more than 1 Year from the date service was rendered will not be considered for payment.**

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefits provision, please see "Determination of Benefits" section.

SCHEDULE OF PODIATRIC ALLOWANCES

	FULL-TIME	PART-TIME
Office, new patient, intermediate service	$ 105.00	$ 52.50
Office established patient, intermediate service	60.00	30.00
Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses); simple	150.00	75.00
Incision and drainage of onychia or paronychia; single or simple	150.00	75.00
Incision and removal of foreign body, subcutaneous tissues; simple	202.50	102.00
Debridement of nails, manual; five or less	45.00	22.50
Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail) for permanent removal	375.00	187.50
Tenotomy, Subcutaneous, toe; single	450.00	225.00
Surgical excision of Morton's neuroma	2,250.00	1,125.00
Ostectomy, partial excision, fifth metarsal head (Bunionette) (separate procedure)	1,125.00	562.50
Ostectomy, calcaneus; partial for spur	1,800.00	900.00
Hemiphalangectomy or interphalangeal joint excision single, each	922.50	462.00
Tenotomy, open, extensor, foot or toe	525.00	262.50
Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)	675.00	337.50
Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)	1,050.00	525.00

SCHEDULE OF PODIATRIC ALLOWANCES (Cont'd)

	FULL-TIME	PART-TIME
Hellux valgus (bunion) correction, with or without Sesamoidectomy; simple exostectomy (silver type procedure)	$1,912.50	$957.00
Keller, McBride or Mayo type procedure with metatarsal osteotomy (Mitchell or Lapidus type procedure)	2,377.50 2,250.00	1,189.50 1,275.00
Hallux valgus (bunion) correction; by phalanx osteotomy	2,062.50	1,032.00
Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction, other than first metatarsal	1,402.50	702.00
Osteotomy for shortening, angular or rotational correction; proximal phalanx first toe (separate procedure)	1,200.00	600.00
Impression of feet orthotics and plaster foot		
Casting and construction of orthotics	450.00	225.00
Cast clubfoot unilateral	150.00	75.00
Cast clubfoot bilateral	375.00	187.50
Splint short leg	202.50	102.00
Strapping ankle	52.50	27.00
Strapping toes	75.00	37.50
Strapping unna boot	112.50	57.00
Aspiration of ankle joint with steroid injection	142.50	72.00
Aspiration and injection of bursa	142.50	72.00
Drainage of subcutaneous hematoma	142.50	72.00
Excision of verruca	525.00	262.50

PRIVATE DUTY NURSING BENEFIT

(IN-HOSPITAL)

This section includes the following:

- Benefit Description
- Exclusions
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Under this benefit, members and their spouses or domestic partners are eligible for reimbursement for private duty nursing costs, provided by a registered nurse or licensed practical nurse only, if hospitalized in an acute care hospital and a doctor orders the nursing. The benefit allowance for the member, spouse or domestic partner is as follows, per person:

Full-Time: $900 per 24-hour period with a per confinement maximum of $5,400

Part-Time: $450 per 24-hour period with a per confinement maximum of $2,700

Exclusions:

- Private Duty Nursing not provided by a registered nurse or a licensed practical nurse,
- Private Duty Nursing not ordered by a doctor,
- Private Duty Nursing not provided in an acute care hospital, and
- Private Duty Nursing provided by a member of the immediate family.

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the member's portion and have your physician complete the physician's portion. **Return the claim form to the Fund Office postmarked within 1 Year after your date of discharge from the hospital with copies of all receipts, insurance payments or other relevant insurance documents. Claims submitted to the Welfare Fund postmarked more than 1 Year after your hospital discharge date will not be considered for payment**.

Coordination of Benefits

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefits provision, please see "Determination of Benefits" section.

PSYCHIATRIC BENEFIT
(OUT-OF-HOSPITAL)

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Under this benefit, members, spouses or domestic partners and eligible dependent children who receive out-patient psychiatric care by a Psychiatrist, a Psychologist, or a Licensed Clinical Social Worker or equivalent in a state other than New York or Licensed Psychoanalyst, will be reimbursed for 50% of the reasonable cost of each visit (not to exceed $75.00 per visit).

MAXIMUM BENEFITS PER PESON EACH PLAN YEAR (July 1 - June 30):

Full-Time	70 visits per family
Part-Time	35 visits per family

LIFETIME MAXIMUMS

Full-Time	Unlimited Family
Part-Time	Unlimited Family

Claim Filing Procedure:

Before you obtain treatment, obtain a claim form from the Fund Office and complete the member's portion. Take the claim form with you to your appointment. Have the provider complete his/her portion of the claim form. Return the claim form with a copy of your bill and the Explanation of Benefit Statements from your other carriers within 1 Year from the date service was rendered. If you have not received Explanation of Benefit Statements from your other carriers in a timely fashion, you should contact the Fund Office **before** the One (1) year deadline for further instructions. **Claims submitted to the Fund postmarked more than One (1) Year from the date service was rendered will not be considered for payment.**

Coordination of Benefits: Please remember that this benefit is coordinated with any other coverage you may have. Please see "Determination of Benefits" section for a complete description of your coordination of benefits provision.

SELF-PAID CONTINUATION OF COVERAGE
(COBRA)

In compliance with a federal law commonly known as COBRA, this Fund offers its members and their covered dependents (called "Qualified Beneficiaries" by the law) the opportunity to elect temporary continuation of group health coverage when that coverage would otherwise end because of certain events (called "Qualifying Events"). This continuation coverage is called COBRA Continuation Coverage.

This section includes the following:

- Benefit Description
- COBRA Continuation Coverage
- Initiating COBRA Continuation Coverage
- Self-Paid Premium
- Termination of COBRA Continuation Coverage
- Entitlement to Social Security Disability Income Benefits
- Second Qualifying Events
- Confirmation of Coverage

Benefit Description:

Members and their covered dependents have the right in most cases to continue to receive health benefits provided by the Fund on a self-paid basis if at a subsequent time they fail to qualify for Employer-provided benefits. Under the law, members and dependents who are covered by the Fund when a Qualifying Event (as described below) occurs are considered Qualified Beneficiaries.

Although domestic partners do not have rights to COBRA Continuation Coverage under existing federal law (and are not considered Qualified Beneficiaries) this Fund will offer this continued coverage to domestic partners in the same manner that it is offered to spouses. Wherever "spouse" is mentioned in this section entitled "Self-Paid Continuation of Coverage (COBRA)", we are also referring to domestic partners.

Qualifying Events are those shown in the chart below. Continuation coverage is available for a maximum of 18 or 36 months in the event coverage terminates, as follows:

Qualifying Event	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Dependent Child ceases to have dependent status	N/A	N/A	36 months

Note that an Employer's bankruptcy under Title 11 of the US Code may trigger COBRA Continuation Coverage for certain retirees and their related Qualified Beneficiaries such as COBRA Continuation Coverage for the life of the retiree. The retiree's spouse and dependent children may be entitled to COBRA Continuation Coverage for the life of the retiree and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the Qualifying Event occurs, but the retiree's surviving spouse is alive and covered by the group health plan, then that surviving spouse may be entitled to coverage for life. Contact the Fund Office if you have questions on this issue.

COBRA Continuation Coverage:

If COBRA Continuation Coverage is elected, the Fund is required to provide coverage that is identical to the current coverage under the medical and/or dental Plan that is provided for similarly situated members or dependents. The legal, life insurance and disability benefits are not offered to COBRA Continuation Coverage participants.

Each Qualified Beneficiary with respect to a particular Qualifying Event has an independent right to elect COBRA Continuation Coverage. For example, both the member and the member's spouse may elect COBRA Continuation Coverage, or only one of them may elect to do so. A parent or legal guardian may elect COBRA Continuation Coverage for a minor child.

Acquiring a New Dependent during the COBRA CONTINUATION COVERAGE Period**:**

If, during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that dependent spouse or child may be enrolled for coverage for the balance of the COBRA Continuation Coverage period on the same terms available to active employees if you enroll the spouse or dependent child in accordance with the Fund's enrollment rules. The same rules about dependent status and qualifying changes in family status that apply to active employees will apply to those dependent(s). There may be a change in your COBRA Continuation Coverage premium amount in order to cover the new dependent(s).

Loss of Other Group Health Plan Coverage:

If, while you are enrolled for COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible for but not enrolled in coverage under the terms of this Plan at the time COBRA Continuation Coverage was initially offered because the spouse or dependent was covered under another group health plan or had other health insurance coverage. The spouse or dependent must have been enrolled in that other coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer

contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 30 days after the termination of the other coverage. Adding a dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage.

If, during the period of COBRA Continuation Coverage, the Fund's benefits change for active members and their dependents, the same changes will apply to you and/or your dependent(s) for COBRA Continuation Coverage.

INITIATING COBRA CONTINUATION COVERAGE:

As a covered employee or Qualified Beneficiary, you are responsible for providing the Fund Office with timely notice of certain Qualifying Events. You must provide notice of the following Qualifying Events:

(1) The divorce or legal separation of a covered employee from his or her spouse.

(2) A beneficiary ceasing to be covered under the Fund as a dependent child of a participant.

(3) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum of 18 (or 29) months. This second Qualifying Event could include an employee's death, entitlement to Medicare, divorce or legal separation or a child losing dependent status.

In addition to these Qualifying Events, there are two other situations where a covered employee or Qualified Beneficiary is responsible for providing the Fund Office with notice within the timeframe noted in this section:

(4) When a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA Continuation Coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA Continuation Coverage.

(5) When the Social Security Administration determines that a Qualified Beneficiary is no longer disabled.

You must make sure that the Fund Office is notified of any of the five occurrences listed above. Failure to provide this notice in the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA Continuation Coverage.

How Should A Notice Be Provided?

Notice of any of the five situations listed above must be provided in writing. You may send a letter to the Fund Office containing the following information: your name, the event listed above of which you are providing notice, the date of the event, and the date on which the participant and/or beneficiary will lose coverage.

When Should the Notice Be Sent?

If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second Qualifying Event, you must send the notice no later than **60 days after the** latest of (1) the date upon which coverage would be lost under the Plan as a result of the Qualifying Event, (2) the date of the Qualifying Event, or (3) the date on which the Qualified Beneficiary is informed through the furnishing of a summary plan description or initial COBRA Continuation Coverage notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund Office.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of COBRA Continuation Coverage.

If you are providing notice of a Social Security Administration determination that you are **no longer** disabled, notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

Who can Provide a Notice?

Notice may be provided by the member or Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the member or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. For example, if a member, her spouse and her child are all covered by the

Plan, and the child ceases to become a dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

Your employer should notify the Fund Office of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also notify the Fund Office promptly and in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Fund Office.

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Fund, or the Fund Office is notified on a timely basis that you died, divorced or were legally separated or that a dependent child lost dependent status, you and/or your dependents will be notified that you and/or they have the right to continue their health care coverage. You and/or your dependents will then have 60 days to apply for COBRA Continuation Coverage. If you and/or your dependents do not apply within that time, health care coverage will end as of the date of the Qualifying Event (with the exception that coverage is extended for 30 days in the event of your death).

Self-Paid Premium:

In the case of a SURVIVING SPOUSE ONLY, the Fund will cover the cost of COBRA premiums for the first twelve (12) months beginning with the first month the surviving spouse is eligible for COBRA coverage. The surviving spouse will be responsible for each monthly premium thereafter for the remaining twenty-four (24) months of COBRA coverage.

The Fund will set premium payments according to federal law, which provides that the self-paid premium may cover the full cost to the Fund for the benefits plus a 2% administrative fee. If the cost changes, the Fund will revise the premium you are required to pay.

The amount you and/or your covered dependent(s) must pay for COBRA Continuation Coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amount due starting with the date COBRA Continuation Coverage was elected. There will then be a grace period of 30 days to pay any subsequent amounts due. **IF THE FUND DOES NOT RECEIVE PAYMENT**

BY THE END OF THE APPLICABLE GRACE PERIOD, COBRA CONTINUATION COVERAGE WILL TERMINATE.

THE FUND WILL NOT SEND MONTHLY BILLS OR REMINDERS TO COVERED MEMBERS OR DEPENDENTS.

Termination of COBRA Continuation Coverage:

COBRA Continuation Coverage will terminate on the earliest of:

- Failure to pay the required premium on time;
- The date the individual becomes covered under another Employer-funded group health Plan either as an employee or dependent unless the individual has a pre-existing condition which the other Plan will not cover. In that event the individual (and eligible dependents) may be allowed to continue his or her COBRA Continuation Coverage for the applicable maximum period or wait until the other Plan's pre-existing condition exclusion no longer applies to that individual. Contact the Fund Office for details.
- The date the individual becomes enrolled in Medicare (except in the case of a Medicare-entitled spouse of a deceased member). However, the individual's non-Medicare-entitled dependents can continue coverage for up to 36 months from the date of the individual's Medicare entitlement.
- The date the group health Plan terminates as to the eligible group of which you were a member. If the coverage is replaced, your coverage will be continued under the new Plan.
- 18 months (maximum) from the Qualifying Event if coverage is being continued for an employee, spouse or dependent because the employee ceased covered employment or lost eligibility due to reduced hours. This may be extended to 29 months (maximum) in the case of a determination of disability by the Social Security Administration. See "Entitlement to Social Security Disability Income Benefits" section.
- 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or dependent for a reason other than the employee's loss or reduction of employment, including the participant's Medicare entitlement.
- Full details of COBRA Continuation Coverage will be furnished to you or your dependents when the Fund Office receives notice that one of the Qualifying Events has occurred. **Therefore, we urge employees and dependents to contact the Fund Office as soon as possible after one of those events.**

When your COBRA Continuation Coverage terminates because of the first three bullets above, the Fund Administrator will notify you in writing of the termination.

Entitlement to Social Security Disability Income Benefits:

If you, your spouse or any of your covered dependents are entitled to COBRA Continuation Coverage for an 18-month period, that period can be extended for a covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if:

- the disability occurred on or before the start of COBRA Continuation Coverage, or within the first 60 days of COBRA Continuation Coverage;
- the disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration within the 18-month COBRA Continuation Coverage period; and
- you or the disabled person notifies the Fund Office of such a determination within that 18-month period.

This extended period of COBRA Continuation Coverage will end at the earliest of: the end of 29 months from the date of the Qualifying Event; the date the disabled individual becomes enrolled in Medicare; or on the date the individual is no longer entitled to Social Security disability benefits. A copy of any Social Security notice terminating the disability benefits should be forwarded promptly to the Fund Office.

Second Qualifying Events:

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA Continuation Coverage period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of

COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

However, if you become entitled to COBRA Continuation Coverage because of termination of employment or a reduction in hours worked that occurred less than 18 months after the date you become entitled to Medicare, and if your spouse and/or any dependent child has a second Qualifying Event as described in the first paragraph of this section, your spouse and/or dependent child would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare.

In no case is a Member whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if a Member experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA Continuation Coverage may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Confirmation of Coverage:

If a provider requests confirmation of coverage and you, your spouse or dependent child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your spouse or dependent child(ren) are within the COBRA Continuation Coverage election period but have not yet elected COBRA Continuation Coverage, COBRA Continuation Coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

KEEP THE FUND INFORMED OF ADDRESS CHANGES

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

CERTIFICATE OF CREDITABLE COVERAGE

When a covered dependent's medical and dental coverage ends, he/she is entitled by law to, and will be provided with, a Certificate of Creditable Coverage that indicates the period of time he/she was covered under the Fund. Such a certificate will be provided to that individual shortly after the Fund knows that coverage for that dependent has ended. In addition, such a certificate will be provided on receipt of a request for such a certificate that is received by the Fund Office within two years after the date coverage has ended. If, within 63 days after your coverage under this Fund ends, a covered dependent becomes eligible for coverage under another group health Plan, or purchases a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply to that individual in the group health Plan or health insurance policy. The certificate will indicate the period of time he/she was covered under this Fund, and certain additional information that is required by law.

The certificate will be sent to a covered dependent by first class mail shortly after his/her coverage under this Fund ends. If a covered dependent elects COBRA Continuation Coverage, another certificate will be sent to him/her by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

In addition, a certificate will be provided to any covered dependent on receipt of a request for such a certificate if that request is received by the Fund Office within two years after the later of the date his/her coverage under this Fund ended or the date COBRA Continuation Coverage ended, if the request is addressed to:

Fund Administrator

Doctors Council Welfare Fund
50 Broadway, 11th Floor, Suite 1101
New York, New York 10004
(212) 532-7690

OTHER IMPORTANT INFORMATION

This section includes:

- Claim Review Procedures
- Members' Rights
- Plan Amendments or Termination
- Discretionary Authority of the Fund Administrator and its Designees
- No Liability for the Practice of Medicine
- Additional Information

The date of these procedures is January 1, 2003. This supersedes any prior version.

Claims and Appeals Procedures

This section describes the procedures for filing claims for benefits from the Doctors Council Welfare Fund (the Fund). It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

How to File a Claim:

A claim for benefits is a request for Fund benefits made in accordance with the Fund's reasonable claims procedures. In order to file a claim for benefits offered under this Fund, you must submit a completed claim form.

Simple inquiries about the Fund's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits.

A claim form, for use with all benefits, may be obtained from the Fund Office by calling: (212) 532-7690.

The following information must be completed in order for your request for benefits to be a claim, and for your claim to be adjudicated:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant
- Dates of Service
- CPT-4 (the code for physician services and other health care services)
- ICD-9 (the diagnosis code)

- CDT code (the code for dental services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address
- If treatment is due to accident, accident details.

When Claims Must Be Filed:

Claims must be postmarked no later than one year from the date services were received, with the following exceptions:

- Disability Benefit claims (initial application) must be postmarked within 3 weeks of the onset of disability.
- Disability Benefit claims (follow-up reports) must be submitted monthly.
- Physical Examination Benefit and Legal Services Benefit require that you call the Fund Office first to verify eligibility, before making an appointment at Affiliated Physicians. You do not need to file a claim for physical examination benefits provided by Affiliated Physicians.
- Healthcare Cost Reimbursement Benefit claims must be postmarked by June 30 in the year following the end of the Fund Year (June 30).

WHERE TO FILE CLAIMS:
Your claim will be considered to have been filed as soon as it is received at the appropriate organization listed below.

For Blood, Hearing Aid, Legal Services, Mammography, Maternity/Adoption, Optical, Physical Examination, Podiatry, Private Duty Nursing and Psychiatric Benefits, please mail claims to/obtain pre-certifications from:

Doctors Council Welfare Fund
50 Broadway, 11th Floor, Suite 1101
New York, New York 10004
(212) 532-7690 (telephone)
(212) 481-4137 (fax)

For Dental Benefits, please mail claims to:

Self Insured Dental Services (SIDS)
303 Merrick Road
PO Box 9005
Lynbrook, NY 11563-9005
516-396-5500; 718-204-7172; 800-537-1238 (telephone)

For Healthcare Cost Reimbursement Benefits, please mail claims to:

Administrative Services Only, Inc.
PO Box 9005
Lynbrook, NY 11563-9005
516-396-5500; 718-204-7172; 800-537-1238

For Disability Benefits, please mail claims to:

Doctors Council Welfare Fund
50 Broadway, 11th Floor, Suite 1101
New York, New York 10004
(212) 532-7690 (telephone)
(212) 481-4137 (fax)

Authorized Representatives:

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

CLAIMS FOR BENEFITS:

The following procedure applies to claims for benefits under the Fund, that is, claims submitted for payment after health services and treatment have been obtained:

1. Obtain a claim form
2. Complete the employee's portion of the claim form
3. Have your Physician/Dentist either complete the Attending Physician's/Dentist's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission
4. Attach all itemized hospital, doctor or dentist bills that describe the services rendered

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

If you or your eligible dependents receive dental services from a provider who participates in the Doctors Council Welfare Fund Participating Dentist Program, you must sign the "Assignment of Benefits" portion of the claim form, enabling payment to be made directly to the dentist. This is not necessary for any other benefits.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for covered services to the Fund or SIDS as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service claim within *30 days* from receipt of the claim by the Fund or SIDS. This period may be extended one time by the Fund or SIDS for up to *15 days* if the extension is necessary due to matters beyond their control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund or SIDS expects to render a decision.

If an extension is needed because the Fund or SIDS needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund or SIDS then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.

<u>Disability Claims:</u>

A **Disability Claim** is any claim that requires you to be under the regular care of a licensed physician and be totally unable to perform the duties of your profession.

For Disability Claims, you and your physician must complete separate claim forms, both of which are available from the Fund Office. Both completed forms must be returned to the Fund within three

weeks of the onset of your disability. The Fund will make a decision on the claim and notify you of the decision within *45 days*. If the Fund requires an extension of time due to matters beyond its control, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within *30 days* of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Fund notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. Once you respond to the request for information, you will be notified of the Fund's decision on the claim within *30 days*.

NOTICE OF DECISION:

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Fund provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures and applicable time limits
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

REQUEST FOR REVIEW OF DENIED CLAIM:

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the organization that first reviewed the claim, either the Fund or SIDS, within *1 Year* after you receive notice of denial.

CLAIM REVIEW PROCESS

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund or SIDS in making the decision; it was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon); it demonstrates compliance with the administrative processes and safeguards of the Fund or SIDS for ensuring consistent decision-making; or it constitutes a statement of Fund policy or guidance regarding the denied treatment or service (regardless of whether it was relied upon).

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund or SIDS on your claim, without regard to whether their advice was relied upon in deciding your claim.

The review will be performed by a person who is different from and not subordinate to the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who did not take part in the adverse benefit determination (and is not subordinate to any individual who did) and who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal:

- **Post-Service Claims:** You will be sent a notice of decision on review within 60 days of receipt of the appeal by the Fund Office or SIDS.

- **Disability Claims:** The Fund will decide your appeal and notify you in writing within 45 days of your request for review. Under special circumstances, an extension of time not exceeding 45 days may be granted for reasons beyond the control of the Fund. If such an extension is required, you

will be advised in writing within the 45 days after receipt of your request for review of the special circumstances and the date a decision will be made.

Notice of Decision on Review:

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific Fund provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

You and your Fund may have other voluntary alternative dispute resolution options such as mediation.

Limitation on When a Lawsuit May Be Started:

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

Members' Rights:

Participants may:

Examine all Fund documents without charge at the Fund Office. These include minutes of Trustees meetings, detailed annual reports and other documents, if any, defining the benefits available to members.

Obtain copies of all Fund documents and other Fund information if copies are requested in writing. There may be a small charge to cover the cost of reproducing the documents.

Receive a summary of the Fund's annual financial report. The Fund Administrator will furnish to all members a copy of this summary annual report.

The people who administer your Welfare Fund are called "fiduciaries". They have a duty to do their job wisely and in the interest of all members and beneficiaries. No one — not the Fund, nor your employer, nor any other person — may in any way discriminate against you to prevent you from obtaining benefits or exercising your rights. If your claim for benefits is denied in whole or in part, you have the right to receive a written explanation of the reason for the denial. You have the right to have the Trustees review and reconsider your claim.

If you have a claim for benefits which you feel is unfairly denied or ignored in whole or in part, you may file suit in a court of appropriate jurisdiction. If the Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from appropriate city, state or federal agencies, or initiate judicial litigation.

If you have any questions about your benefits, please contact the Fund Office.

Plan Amendments or Termination:

The Trustees reserve the right to amend or terminate this Plan, or any part of it, at any time. Amendments may be made in writing by the Trustees and become effective on the date specified in the document amending the Plan. The Trustees may terminate the Plan or any coverage, and the Trustees may add new coverage.

Discretionary Authority of the Fund Administrator and its Designees:

In carrying out their respective responsibilities under the Fund, the Trustees, and other Fund fiduciaries and individuals to whom responsibility for the administration of the Fund has been delegated, will have discretionary authority to interpret the terms of the Fund documents and to determine eligibility and entitlement to Fund benefits in accordance with the terms of the Fund. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

No Liability For the Practice of Medicine:

The Fund, the Fund Trustees and their designees are **not** engaged in the practice of medicine, nor do they control the diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you and your covered dependents by a health care provider. Neither the Fund, the Trustees, nor their designees, will have any liability whatsoever for any loss or injury caused to you by a health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Additional Information:

The information in this booklet contains only a summary of the features of your coverage. This booklet is not a contract. The terms and conditions of the Fund documents determine eligibility for membership benefits.

Fund Sponsor:	Doctors Council Welfare Fund
EIN Number Assigned by the Internal Revenue Service:	13-2938751
Fund Administrator:	Board of Trustees of the Doctors Council Welfare Fund
Agent for Service of Legal Process:	Fund Administrator
Official Name of the Plan:	Doctors Council Welfare Fund
Type of Plan:	Welfare Fund
Type of Administration:	Insured and Self-Insured
Plan Year:	July 1 - June 30

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