

The image features a tiger in the foreground, roaring with its mouth wide open, showing its teeth. The tiger is positioned in the lower right quadrant. The background shows a park-like setting with trees and a path, and a large, classical-style building with a dome and columns in the lower left. The entire image has a warm, orange-red color cast.

**District Council 37**

**Cultural Institutions  
Health and Security**

**Plan Trust**

**Benefits Booklet**

## **District Council 37 Cultural Institutions Health & Security Plan**

The benefits described in this booklet are available through the DC 37 Cultural Institutions Health & Security Plan (the “Plan”), a group health plan. By agreement between the Plan and the District Council 37 Health & Security Plan (the “H&S Plan”), benefits are administered by the H&S Plan in accordance with the H&S Plan’s rules and guidelines. Eligibility for the benefits payable under the Plan, and the benefit allowances and guidelines are subject to change, at any time and for any reason, by the Board of Trustees of the Plan (the “Trustees”), in its sole and absolute discretion. If you have any questions, contact the Plan’s Inquiry Unit at 212-815-1234.

**Revised: 2017.**

**Please note: This summary plan description provides benefit information as of the above revision date. For the most current benefit information and guidelines you are advised to use this link to the website [www.dc37.net](http://www.dc37.net) or contact the Plan’s Inquiry Unit at 212-815-1234.**

## **District Council 37 Cultural Institutions Health & Security Plan Trust**

H&S Plan Office: 125 Barclay Street, New York, New York 10007.  
(212) 815-1234

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## MESSAGE FROM THE TRUSTEES

Dear Member:

We are pleased to present you with this booklet, also called a Summary Plan Description, which summarizes the benefits to which members (“participants”) of the District Council 37 Cultural Institutions Health & Security Plan (the “Plan”) are entitled. This booklet also explains how to determine whether you are eligible for benefits and how to submit claims in order to receive benefits. In addition, it provides you with an explanation of your rights and responsibilities under the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended.

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

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

Your particular attention is directed to the various deadlines for filing claim forms in order to obtain benefits. These deadlines, which are strictly applied, are set forth on page 42.

We also call to your attention that the Trustees have the authority, in their sole and absolute discretion, to amend, modify or terminate the Plan at any time, and the sole and absolute discretion to interpret the Plan provisions and all official Plan documents. Please see page 49 for more information concerning this authority.

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

After reading this booklet, if you have questions concerning the benefits to which you are entitled, please feel free to contact the Health and Security Plan's Inquiry Unit at 212-815-1234, or the Education Fund at 212-815-1700.

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

In Solidarity,

**The Trustees**

## NOTICE OF GRANDFATHERED STATUS

The Plan believes – that, to the extent that it provides certain supplemental health-related benefits, it is a “grandfathered health plan”, as defined under the Patient Protection and Affordable Care Act (the “Affordable Care Act”, also known as “Health Care Reform”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and extension of coverage of dependents to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at DC 37 Health & Security Plan, 125 Barclay Street, New York, NY 10007. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.



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## PART I. ELIGIBILITY FOR BENEFITS

### WHO IS ELIGIBLE FOR THESE BENEFITS?

**Eligible members, retirees and dependents as defined below are generally collectively referred to as “Participants.”<sup>1</sup>**

#### **Members and Retirees**

You are eligible for benefits as described in this booklet if you are a regular full-time active member of The Cultural Institutions and work in a job title (shown below) that is covered by the collective bargaining agreement between Cultural Institutions and District Council 37 or you are an eligible retiree.

American Museum of Natural History  
Brooklyn Academy of Music  
Brooklyn Botanic Garden  
Brooklyn Children’s Museum  
Brooklyn Museum  
Cary Arboretum  
El Museo del Barrio  
Hall of Science  
Metropolitan Museum of Art  
Museum of the City of New York  
New York Botanical Garden  
Queens Botanical Garden  
Staten Island Historical Society  
Staten Island Institute of Arts and Sciences  
Staten Island Zoological Society  
Wavehill  
Wildlife Conservation Society

Employees working in a covered job title other than the Wildlife Conservation Society (“WCS”) and the Brooklyn Museum become eligible for these benefits as of the first day of employment. Employees of the Wildlife Conservation Society and the Brooklyn Museum become eligible for these benefits the first day of the month following three months of employment with WCS or the Brooklyn Museum.

Retirees become eligible if they retire on or after the Institution’s effective eligibility retirement date and are a members of the Cultural Institutions Retirement System or the Metropolitan Museum of Art Retirement Plan.

*Former employees of Cary Arboretum and Wavehill are not eligible for Retiree Benefits.*

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<sup>1</sup> As this Summary Plan Description is for the benefit of Participants, the text will sometimes refer directly to the Participant who is eligible for the described benefits using the words “you,” and “your” etc.

## Eligible Dependents

Some of a member/retiree's dependents may also be eligible for benefits. A member/retiree's eligible dependents include his/her spouse/domestic partner and dependent children as described below.

**A member/retiree's "spouse/domestic partner"** is an individual who is the member/retiree's legal spouse, or partner in a civil union or domestic partnership recognized by the State of New York.

### Dependent Children

An eligible dependent child is covered up to the end of the month in which he/she reaches the age of twenty-six (26).

**"Eligible Dependent Children"** include:

- The member/retiree's biological child;
- The member/retiree's legally adopted child (including children placed in the home for the purposes of adoption);
- The member/retiree's step-child;
- The child of member/retiree's domestic partner;
- Children under a court appointed **guardianship** who are the member/retiree's legal dependent.

Note: Proof of guardianship must be received by the Plan, prior to the child's 18th birthday.

### Disabled Dependent Children

If an Eligible Dependent Child becomes disabled on or before the last day of the month in which he attains his twenty-sixth (26th) birthday, the Board of Trustees shall continue benefits during the period of total disability without regard to age provided that:

- The child becomes or became totally disabled on or before the last day of the month in which he/she attains his/her twenty-sixth (26th) birthday.
- Proof, which may include medical records and or clinical evaluation(s) of such ongoing disability is provided to the Plan periodically as requested. If the disabled dependent is twenty-six (26) and over, and ceases to be totally disabled, the Board of Trustees shall consider the dependent ineligible for benefits, even if the disability reoccurs at a later date.

Notes:

- Total Disability shall mean an infirmity of body or mind arising out of a non-occupational sickness or non-occupational accidental injury which prevents a person from engaging in any occupation for wage or profit as determined in the sole discretion of the Board of Trustees.
- The Board of Trustees, in their sole discretion, shall determine whether a dependent is totally disabled and thus eligible for benefits as a Disabled Dependent Child.

- The Board of Trustees shall also find the dependent ineligible if the disability occurred due to alcohol or substance abuse, or any other self-inflicted injury that the Board of Trustees, in their sole discretion, determines to render the dependent ineligible to receive benefits.

## **GENERAL ELIGIBILITY RULES**

### **When does eligibility begin?**

Active members working in a covered job title become eligible for these benefits on the first day of employment; except for employees of the Wildlife Conservation Society (“WCS”) and the Brooklyn Museum who become eligible for these benefits on the first day of the month following three months of employment with WCS or the Brooklyn Museum. Retirees become eligible on the effective date of retirement.

**Loss of Eligibility** A Participant’s eligibility for all benefits stops when the covered member is no longer on the payroll (except when the member is on an approved unpaid FMLA leave) or collecting a pension, is laid off or moved into a job title not represented by DC 37, or no longer satisfies the Plan’s definition of full-time or part-time active salaried employee or retiree. However,

- If the Participant is in the middle of getting covered treatments done on their teeth, they have sixty (60) days after becoming ineligible for benefits to complete certain treatment in progress.
- If the member goes off payroll because of a disability, he/she and any eligible dependents continue to be eligible for up to six (6) months while the member is collecting disability benefits or Workers’ Compensation payments through his/her employer. Please see page 24 for details.
- In the event of the member/retiree’s death, the covered spouse/domestic partner continues to be eligible for benefits for twelve (12) months and may elect COBRA for an additional twenty-four months (24), if they were otherwise eligible to receive benefits. See page 35 for more information on Survivor Benefits.
- The Participant may also have the right to continue medical coverage on a self-pay basis under COBRA – see page 55 for a detailed description.
- If, after becoming eligible, the member is laid off or otherwise terminated and is rehired within twelve (12) months in a Covered Job Title, eligibility resumes as soon as member has worked a full day.

**Retiree benefits are not vested.** As with the benefits provided to active members, retiree benefits are funded through the ongoing contributions made to the Plan by the contributing employers. As with the benefits provided to active members and their families, the Trustees reserve the right to amend, suspend or eliminate the benefits received by retirees and their beneficiaries. Among the circumstances which might cause the Trustees to take such action would be a cessation or reduction in the amount of contributions being received from the contributing employers on behalf of the retirees.

### **Misconduct and other events**

Of course, there are some acts of misconduct which may result in the limitation or deprivation of benefits otherwise available under this Plan. Should a situation of this nature arise, you will be advised of that fact and be given an opportunity to respond.

### **Requirement to Notify the Plan Upon Loss of Dependent Eligibility**

A member/retiree is responsible for notifying the Plan of any change of status which results in a covered dependent losing eligibility as such under the Plan. This includes but is not limited to: a death, legal separation, divorce or dissolution of civil union/ domestic partnership, termination of adoption, or a termination of a legal guardianship or custody order. If any such change of status occurs, you must notify the H&S Plan Office of this on a Change of Status Form, but supporting documents are not necessary.

**Please Note:** A member will be responsible for reimbursing the Plan for the cost of any benefits which are provided to a dependent who has become ineligible due to a change of status if the member failed to provide notice to the Plan of such change of status. In addition, failure to inform the Plan of such a change of status may constitute fraud.

### **Prohibition Against Rescission of Coverage**

The Affordable Care Act (through Public Health Service Act, Section 2712) generally provides that plans and issuers must not retroactively cancel coverage unless there is fraud or an individual makes an intentional misrepresentation of material fact. A rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage.

### **Qualified Medical Child Support Orders**

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

## ENROLLMENT AND CHANGE OF STATUS

**A MEMBER/RETIREE'S ENROLLMENT FORM WITH ANY REQUIRED DOCUMENTATION MUST BE ON FILE WITH THE PLAN BEFORE A MEMBER/RETIREE OR THEIR ELIGIBLE DEPENDENT CAN OBTAIN BENEFITS.**

A member *enrolling for the first time* must attach copies of any required supporting documentation to the **Enrollment Form** when enrolling a spouse/domestic partner or dependent child for Plan benefits. Members are eligible for coverage from their first day of employment. However, coverage for benefits will not begin until a completed enrollment form is received by the Plan. Eligible dependents will not be covered for benefits until all the required documentation is received by the Plan.

A retiree must also submit a copy of his/her pension check stub and health insurance form to be enrolled in retiree benefits.

An *existing member/retiree who is already enrolled for benefits* must complete a **Change of Status Form** and provide the required documentation before any new eligible dependents can be enrolled.

Participants must also submit a copy of their Medicare card to the Plan office when they become eligible for Medicare Part A and B.

If the member/retiree or dependent has a change of name or address, or if a death, marriage, domestic partnership, birth, court order, adoption, divorce, separation or dissolution of domestic partnership has changed the size of the family, the Plan must be told of the changes by filling out a **Change of Status form**.

All Forms must be completed and signed by the member/retiree. All **Enrollment Forms** and **Change of Status Forms**, along with supporting documents, should be sent to the District Council 37 Health & Security Plan, 125 Barclay Street, New York, New York, 10007 Attention: Eligibility Enrollment Unit.

### Enrolling Eligible Dependents

The member/retiree must provide certain required documentation when enrolling a spouse/ domestic partner or dependent child, including: marriage certificate, civil union or domestic partnership papers, documentation of spouse/domestic partner's employment and health coverage status, child's birth certificate, adoption papers and other documentation requested by the Plan.

In the case of **guardianship**, the member/retiree must provide certain documentation to maintain the child's eligible status, including:

- A copy of the child's birth certificate;
- A Legal Order of Guardianship or Custody;
- *For each year of eligibility*: a copy of IRS form 1040 showing that the member/retiree has claimed the child as a dependent.
- Documents establishing guardianship relationship must initially be provided before the child's 18th birthday.

### **Change of Beneficiary**

If you are changing your status, please consider updating your Death Benefit beneficiary information. For example, if you designate your spouse as your beneficiary and then get divorced and subsequently married to someone else, your ex-spouse will remain the beneficiary of your Death Benefit unless you fill out a Change of Beneficiary Form. The Change of Beneficiary Form must be signed and notarized. For more information or to request a Change of Beneficiary Form visit [www.dc37.net](http://www.dc37.net) or call the H&S Plan Office at (212) 815-1531.

## **COORDINATION OF BENEFITS**

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

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

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

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

1. When this Plan provides primary coverage to the member and eligible dependents, the Plan will pay full benefits, up to the Plan’s maximum coverage.
2. When this Plan provides secondary coverage to an eligible dependent, the Plan will pay the difference between: (a) The dependent’s out-of-pocket costs or the usual and customary cost for the covered treatment, service or prescription drugs, whichever is lower, and (b) The amount of reimbursement or payment received by or on behalf of the eligible dependent from the other plan(s). In no case will the Plan’s payment exceed its maximum coverage for such a benefit.

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

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



## **BENEFITS OUTLINE**

The following benefits are available to you and your eligible dependents as described:

### **I. Health & Security Benefits (“H&S Benefits”)**

**1. H&S Benefits available to you (the member or retiree) and your eligible dependents:**

- Second Surgical Consultation
- Dental Benefit
- Prescription Drug Benefit
- Vision Care Benefit
- Health & Pension Counseling
- Personal Service Unit
- Survivor Benefit

**2. Benefits available only to you (the member or retiree):**

- Death Benefit
- Accidental Death and Dismemberment Benefit (retirees not eligible)
- Disability Income Benefit (retirees not eligible)
- Audiology

**3. Benefits available to retirees only:**

- Medicare Part B Reimbursement (as determined annually by the Trustees)

### **II. Education Benefits**

Education benefits are available *only* to you (the member).

As noted elsewhere in this booklet, under certain circumstances, you, your spouse/ domestic partner and your eligible dependents may cease being eligible for benefits under the Plan. Please note, however, that you may be entitled to a temporary extension of health benefits under limited circumstances. See section regarding COBRA benefits on page 55 of this booklet.

## **PART II: HEALTH & SECURITY BENEFITS**

### **INTRODUCTION**

The Plan was formed to provide ancillary health and welfare benefits and services for active members and retirees.

A primary concern of the Plan is to provide prompt processing of the thousands of claims received each year.

Another major concern is to ensure that members receive high-quality medical and health care services. As part of its monitoring program, the Plan evaluates the services offered by some of the vision care providers on a regular basis, as well as monitoring the utilization of the Prescription Drug benefit. In addition, the dental treatment received by our members from participating panel and other private dentists is reviewed on a periodic basis to make sure that the work is necessary. This is why the Mandatory Pre-Authorization Policy (described herein) was instituted.

In addition to providing various benefits to our members, we are constantly evaluating our programs, procedures and systems, as well as exploring new ways of providing benefits and services. Our continuing goal is to see to it that our members receive benefits of the broadest nature possible, that their health care is of high quality, and that the services are delivered in a cost-efficient manner.

In order for the Plan to properly administer these benefits, it is important to ensure that the Plan has your current address, phone number and email address on file. Also, make certain that you keep your beneficiary information up to date.

## DENTAL BENEFIT

There are two ways of using the dental benefit:

- 1) A Participant may use any licensed dentist who provides these services. The Participant will be reimbursed by the Plan based on its fee schedule for covered services and will be responsible for any difference between the Plan's fee schedule and the dentist's charges. Participants should check the dentist's fees and our fee schedule before having any work done. Plan restrictions, limitations and annual dollar limit will also apply.
- 2) A Participant may use any dentist from the Plan's list of Participating Dentists which is updated monthly. A Participating Dentist accepts the Plan's fee schedule amount as full payment for covered procedures. The Participant will be responsible for any cost incurred if they obtain treatment that is restricted or obtain treatment not covered on the fee schedule or the cost is above the annual dollar limit allowed. Contact the Plan's Inquiry Unit at (212) 815-1531 or visit our web site at [www.dc37.net](http://www.dc37.net) to obtain a listing of panel providers.

Note: It is your responsibility to make sure that your dentist completes the appropriate sections of any claim, and that all claims are submitted timely, within 90 days after the completion of treatment.

*Standard Benefit:* A maximum of \$1,700 will be paid as benefits for each covered Participant in a calendar year based on the fee schedule.<sup>2</sup> Benefits are paid after claim forms for completed services are submitted to the Plan and processed based on Plan rules and guidelines.

You have the right to opt-out of the Plan's dental benefit coverage. Please call the Plan at (212) 815-1234 for more information.

## CONTINUATION OF TREATMENT

If a member is terminated or retires from employment for any reason except total disability – (members receiving Disability Benefits are eligible for benefits for a maximum of six months from the date of their disability) – while having dental work done, the Plan will continue to cover certain services<sup>3</sup> already begun for up to 60 days after termination or retirement. This is also true for the member's eligible dependents.

## CLINICAL DENTAL EVALUATION

Participants may be required, on occasion, to be clinically evaluated by a dentist selected by the Plan as part of the Plan's continuing effort to monitor the quality of care our members receive. An evaluation may be performed for work planned but not yet done, or for work completed and billed. A Participant's failure to comply with such a request may result in a denial of benefits.

Of course, the Plan will make every effort to schedule such an evaluation at a time convenient to the Participant.

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<sup>2</sup> As with all decisions regarding eligibility for and the amount of benefits payable under the Plan, these allowances and guidelines are subject to change, at any time and for any reason, by the Board of Trustees of the H&S Plan, in its sole and absolute discretion.

<sup>3</sup> Only orthodontics, prosthetics or root canal therapy.

## **MANDATORY PRE-AUTHORIZATION**

Pre-authorization is mandatory before beginning treatment for prosthetics (dentures and bridgework), crowns, extensive gum treatment, TMJ therapy, root canal therapy or orthodontics. This pre-authorization is for your benefit. You get a free second professional opinion to determine if the work is necessary. In addition, you will have advance notice of the extent of the dental work involved and of the cost of such work. **YOU MUST SUBMIT A REQUEST FOR PRE-AUTHORIZATION FOR THE ABOVE LISTED SERVICES PRIOR TO GETTING THE WORK DONE. A CLAIM FOR COMPLETED SERVICES WILL BE REJECTED IF YOU DID NOT RECEIVE A PRE-AUTHORIZATION FOR SUCH WORK.**

You or your dentist may obtain a pre-authorization form from the H&S Plan Office or at our website at [www.dc37.net](http://www.dc37.net). Your dentist will describe the proposed work, and attach x-rays to show that the work is necessary. You and your dentist should complete the form and send it to the H&S Plan Office. The H&S Plan Office reviews the pre-authorization plan, then notifies you and your dentist if the intended work is covered and for how much. **THIS ASSUMES, OF COURSE, THAT YOU ARE ELIGIBLE FOR BENEFITS WHEN THE WORK IS PERFORMED**, and takes into consideration the Plan's rules and regulations regarding yearly maximums and frequency limitations for certain procedures.

Information on how to obtain benefits is on pages 37 & 38.

## **GUIDELINES OF THE PLAN'S DENTAL SERVICES**

**DENTAL TREATMENTS ARE COVERED ONLY IF THEY ARE DONE BY, OR UNDER THE SUPERVISION OF, A LICENSED DENTIST.**

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

**Regular Examinations and Cleaning:** Once every six months, measured from the date of service, Participants can have their teeth examined by a licensed dentist to check for cavities and other dental or oral problems. Participants can also have their teeth cleaned and scaled once every six months.

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

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

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

**Fillings:** To repair decayed teeth.

**Extractions:** And other oral surgery covered as required.

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

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

**Periodontia:** Gum treatments and necessary periodontal care. If the Participant uses the periodontal panel, there is a \$10 per quadrant co-payment for periodontal surgery.

**Orthodontics:** The Plan will pay up to \$1,840 for this benefit. This is how the benefit is applied: The Plan pays up to \$400 for diagnosis and the orthodontic appliance, then up to \$60 a month for adjustments. The lifetime maximum for the orthodontia benefit is \$1,840.

#### **Dental Benefit as it Pertains to Part-Time Employees**

This benefit covers the same range of services **with the exception of orthodontics**. Members who are part-time employees and their eligible dependents are **not** covered for orthodontia.

For members who are part-time employees and their eligible dependents, the Plan will reimburse at 75%, on a procedure basis, based on the DC 37 Dental Fee Schedule. A Participant would be responsible for the balance of his or her dental bill, which would be the remaining **25% of the total cost plus any difference between the actual dentist charges and the Schedule Amount**.

The following example shows how Part-Time benefit payments are calculated:

A	B	C	D	E	F	G
Dental Procedure	Dentist's Actual Charges	Schedule Amount	Difference (B - C)	Plan's 75% of (C) Schedule Amount	Member's 25% of (C) Schedule Amount	TOTAL Amount Member Pays (D + F)
Initial Oral Exam	\$35	\$25	\$10	\$18.75	\$6.25	\$16.25
X-Rays 16 - 19 & BW	\$60	\$40	\$20	\$30	\$10	\$30
Amal (3) Perm (filing)	\$100	\$50	\$50	\$37.50	\$12.50	\$62.50
<b>Total</b>	\$195	\$115	\$80	\$86.25	\$28.75	\$108.75

The Dental Benefit would pay 75% of the Schedule Amount, or \$86.25. The Participant would be responsible for the other 25% (\$28.75) in addition to the difference between the actual charges and the Schedule Amount. The Participant's total responsibility would be \$28.75 + \$80 = \$108.75.

### **Dental Benefit as it Pertains to Retirees**

The Dental Benefit, as it pertains to retirees of the DC 37 Cultural Institutions Trust, is currently identical to the benefit for members who are full-time active employees, with the exception that the **orthodontia benefit is only available to eligible dependent children**. The retiree and spouse/domestic partner are not covered for orthodontia.

*Please note that if you started the orthodontic benefit as an active employee and you retire without completing this benefit, you will not be eligible for any further orthodontic benefits as a retiree.*

### **Participating Dentists**

A list of dentists who have agreed to accept the fees listed in the allowable schedule as full payment for the described procedures and service is available. These dentists are called Participating Dentists. If a Participating Dentist is used, members who are full-time employees or retirees (and their eligible dependents) will not incur any out-of-pocket costs for covered procedures and services except as noted regarding periodontia. Members who are part-time employees (and their eligible dependents) will be responsible for 25% of the cost for covered procedures and services.

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

### **COVERAGE EXCLUSIONS SUMMARY**

1. In general, any dental work begun before the Participant becomes eligible for dental benefits will not be covered, even if completed after the Participant becomes eligible. For example, if a root canal was opened before becoming eligible, the root canal therapy will not be covered even if done at a later date. If the participant has a tooth prepared for a cap before becoming eligible, the cap is not covered, even if it is put on after eligibility is established.
2. Benefits are not payable for more than one examination and cleaning per Participant in any six (6) consecutive months.
3. The Plan does not pay an additional fee for the completion of forms.
4. Benefits are not payable for a prophylaxis rendered the same day as a periodontal treatment.
5. Benefits for topical application of stannous and sodium fluoride are not payable for persons over 18 years of age.
6. Stannous and sodium fluoride treatments for persons under 18 years of age are not payable more than once every six (6) months.
7. Occlusal adjustments are limited to one full mouth adjustment every five (5) years.

8. No additional allowance will be provided to connect or disconnect units involved in fixed bridgework.
9. Benefits are not payable for temporary crowns unless necessitated by an accidental injury to natural teeth.
10. A temporary restoration (except when necessitated by accidental injury) is considered part of, and is included in the allowance for, the final restoration.
11. No additional benefits will be provided for post-operative treatment.
12. Payment is limited to: a) two pins per tooth, and b) \$55 filling benefit per tooth.
13. Benefits are not payable beyond a maximum of \$1,700 per covered individual per calendar year.
14. Benefits are not payable for the following: (i) an appliance, or modification of an appliance, for which an impression was made before the person became a Participant, or (ii) a crown, bridge or gold restoration, for which a tooth was prepared before the person became a Participant, or (iii) root canal therapy, for which the pulp chamber was opened before the person became a Participant.
15. Benefits are not payable for a partial or full removable denture or fixed bridgework if it involves replacement of one or more natural teeth extracted prior to the member being in a covered job title for a consecutive 12-month period, unless the denture or fixed bridgework also includes replacement of a natural tooth which (i) is extracted while the person is such a Participant and (ii) was not an abutment to a partial denture or fixed bridge installed within the immediately preceding five years.
16. Benefits are not payable for a new partial or full removable denture or fixed bridgework, or a crown or gold restoration, if it involves the replacement of a denture, bridgework, crown or gold restoration which was inserted during the immediately preceding five (5) years. The 5-year period shall always commence on the date the device(s), paid for by the Plan, were inserted.
17. Benefits are payable for a precision denture up to the maximum scheduled benefit allowable for a cast - or acrylic-base partial denture with a gold or chrome lingual or palatal bar with two clasps. However, crowns inserted as abutments for precision or semi-precision attachment appliances and cast - or acrylic-based partial dentures are not covered except where necessitated by either periodontics or restorative reasons.
18. Adjustments to dentures and space maintainers are considered part of the allowance if made within four (4) months of installation. The relining of an immediate denture will be considered after four (4) months from the insertion date. An office reline will be limited to once every twelve (12) months. A laboratory reline will be limited to once every twenty-four (24) months.
19. Any service not listed in the Plan's fee schedule will be excluded except as follows: If a charge is incurred for a service not included in the schedule, in connection with the dental care of a specific covered condition, and if the

schedule contains one or more services which, according to customary dental practices, are in the Plan's opinion, appropriate for the dental care of that condition, then a charge for the least expensive of such services as are included in the Schedule will be considered to have been incurred in lieu of the charge actually incurred.

20. Expenses incurred after the termination of a person's coverage are not reimbursable except as otherwise noted.
21. Charges in excess of the scheduled fee shown in the Plan's benefit schedule.
22. Charges for procedures rendered before a person becomes eligible for benefits.
23. A service not reasonably necessary, or not customarily performed, for the maintenance of the patient's health.
24. A service furnished a person for cosmetic purposes, unless necessitated as a result of an accidental injury sustained while the person was a covered individual.
25. Facing on crowns, or pontics, which are posterior to the first molar are considered cosmetic and are excluded in accordance with exclusion 24 above.
26. Any employment-related disease or injury to the teeth, which is covered by any Workers' Compensation law, occupational disease law or similar legislation.
27. A service or supply (i) furnished by or for the U.S. Government, (ii) furnished by or for any other government unless payment is legally required, or (iii) to the extent any benefit is provided by any law or government program under which the person is or could be covered.
28. Charges covered by another group dental insurance plan. See section regarding "Coordination of Benefits" for specifics.
29. Replacement of lost or stolen appliances.
30. Any dental service, which is not furnished by a licensed dentist, unless performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a licensed dentist.
31. Services covered by any other medical or surgical benefit or insurance program.
32. Charges for oral hygiene instruction, dietary planning, etc.
33. Dental supplies, including, but not limited to, toothbrushes, toothpaste, mouthwash, water-piks, etc.
34. Payment for periodontal surgery is restricted to once every five (5) years. Each quadrant will be considered individually.

Please note: The DC 37 Dental Center is not available for use by Plan Participants.



## VISION CARE BENEFIT

### Standard Benefit

Once every two (2) years, measured from the Participant's last date of service, Participants may receive a Vision Care Benefit, also called the Optical Benefit, which includes an eye examination, and if needed, eyeglass frames and eyeglass lenses. Participants may not need all three parts of the Vision Care Benefit. The examination may show that the participant needs only new frames and not new lenses. If so, only the necessary services will comprise the complete Vision Care Benefit for the two-year period. Example: If a Participant files a claim for reimbursement for an eye examination and single vision lenses obtained on April 1, 2017, he or she will be reimbursed \$15.00 for his/her Optical Expense claim. If the Participant files a claim for reimbursement for an eye examination, single vision lenses and frames he or she will be reimbursed \$20.00. In both examples, the Participant will once again become eligible for Optical Benefits on or after April 1, 2019 (after two (2) years have elapsed).

You have the right to opt-out of the Plan's optical benefit coverage. Please call the Plan at (212) 815-1234 for more information.

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

**1. Using a Voucher** - You can call or write to the H&S Plan Office and request a voucher. The Voucher is accepted by the participating optometrist or optician as full payment for the examination, lenses and DC 37 approved frames, as listed in the schedule on the following page.

Please note: if you use a participating panel provider in Florida, you are required to pay a fixed out-of-pocket co-payment for covered services.

You have to use the Voucher within ninety (90) days of the date of issuance. If the Voucher is lost, destroyed or stolen, you must submit a notarized copy of the Lost Optical Statement form indicating that the Voucher was lost, destroyed or stolen. If an optical Voucher expires, you must return the expired Voucher to the H&S Plan Office at 125 Barclay Street, Optical Unit, Eighth Floor, New York, New York 10007, and indicate if you wish to receive a new Voucher, or simply wish to void the expired Voucher. Upon receipt of the expired Voucher, we will void it and correct your optical history file. We can then issue another Voucher whenever you ask. A listing of participating optical providers is available at the H&S Plan Office and on our website at: [www.dc37.net](http://www.dc37.net).

**2. Using Direct Reimbursement** - You must fill out the Optical Benefit Reimbursement Form (obtainable from the H&S Plan Office or online at [www.dc37.net](http://www.dc37.net)) and return it to the Plan for reimbursement. The Plan will reimburse you for what you spent for each procedure or item up to the amounts listed on the following fee schedule:<sup>4</sup>

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<sup>4</sup> As with all decisions regarding eligibility for, and the amount of benefits payable under, the Plan, these allowances are subject to change by the Board of Trustees at any time and for any reason. If you have any questions contact the Plan office.

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Eye Examination . . . . .	\$ 6
Single Vision Lenses (Standard lenses) . . . . .	\$ 9
Bifocal Lenses (Standard lenses) . . . . .	\$16
Trifocal Lenses (Standard lenses) . . . . .	\$20
Progressive Lenses (Standard lenses) . . . . .	\$16
Frame . . . . .	\$ 5
Plastic Aspheric Single Vision Cataract Lenses . . . . .	\$40
Plastic Aspheric Bifocal Cataract Lenses . . . . .	\$65
Contact Lenses . . . . .	\$14
Cataract Contact Lenses . . . . .	\$45

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Please note that cataract contact lenses can only be obtained through the direct reimbursement method.

**REMINDER**

In order to maximize your Optical Benefit you must obtain and file for all three services (eye examination, lenses and frames) simultaneously on the same claim form whether using the Voucher or direct reimbursement method. The three parts of the benefit cannot be split between the two available methods, Voucher or Direct Reimbursement. You should be aware that partial usage of the benefit will be considered the same as full usage. That is to say, if you receive an examination only and you do not obtain lenses and frames, you cannot use any part of the Standard Benefit again for two (2) years. The two-year period is measured from the date of the examination if only an exam was obtained, or the date of payment if lenses and frames were also obtained.

**Information on filing Optical Benefit claims is on pages 37 & 38.**

## PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit pays the cost, minus applicable co-pay and ancillary charges, of U S Food and Drug Administration (“FDA”) approved prescription drugs which are on the H&S Plan’s formulary and which are prescribed for an FDA approved indication.<sup>5</sup>

### Generic-Based Prescription Drug Benefit - Active Members and non-Medicare Eligible Retirees

The Plan has a generic-based Prescription Drug Benefit for active members, non- Medicare eligible retirees and their eligible dependents. This means that the Plan will only be responsible for paying for covered prescription medication at the generic rate, except when there is no generic available and the brand name drug is the only drug available (sole source). It is important to note that FDA requires that generic drugs must meet the same standards for purity, strength and safety as the brand name drug.

The Prescription Drug Benefit consists of a three-tier co-payment program. The following co-payments are in effect as of January 1, 2017:

DRUG	30-day supply at Retail Pharmacy	90-day supply at Retail Pharmacy	90-day supply at Voluntary Mail-Order Pharmacy
Generic	\$10	\$30	\$20
Preferred Brand	\$20	\$60	\$40
Non-Preferred Brand	\$45.50	\$136.50	\$91

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

### PICA

**Although it formerly covered Psychotropic and Asthma medicines as well, effective July 1, 2005, the City-sponsored program continues to cover just two (2) classes of medication: Injectibles and Chemotherapy. Psychotropic and Asthma medication coverage reverted to the Plan’s responsibility and are subject to Plan rules and co-payments.**

**Plan Participants covered by the program must use their City of New York PICA prescription card for injectibles and chemotherapy medication. Questions about the PICA program should be directed to the telephone number on the back of the NYC PICA prescription card.**

<sup>5</sup> While allergens are not prescription drugs, some allergens are covered under the Plan if the medication is purchased from an allergy testing lab or a Participating Pharmacy and is prescribed by your doctor.

## How to Use the Prescription Drug Card

The most effective way of using your Prescription Drug Benefit for short-term medication is with the prescription drug card issued by the Plan. As this benefit is generic-based, please discuss with your physician filling your prescription with a generic drug. Doing so will save you and the Plan money. Remember to take your card with you to the pharmacy. When getting medication from your neighborhood participating pharmacy, you can obtain a 30-day supply or, in some cases, a 90-day supply based on your written prescription for the appropriate Plan co-payment. For maintenance drugs, you are encouraged to use the Plan's mail order program where you can obtain a 90-day supply of prescription drugs for only two (2) co-payments. Certain specialty drugs that require special handling are filled through a specialty mail-order pharmacy. In the event that you did not receive a valid prescription drug card, or if your card has been stolen, lost or destroyed, you must notify the H&S Plan Office by calling the Inquiry Unit at 212-815-1234.

## How to use the Direct Reimbursement Method

If you do not have your prescription drug card with you at the pharmacy, or if you do not go to a participating pharmacy, you must utilize the Direct Reimbursement Method to obtain your prescription drugs. You must complete the Prescription Drug Benefit Reimbursement form (available online at [www.dc37.net](http://www.dc37.net)), and send the form along with the prescription receipt to the Plan's Prescription Drug Benefit Administrator at: DC 37 Health & Security Plan, 125 Barclay Street, Attn: Drug Unit 8th Floor, New York, NY 10007, in order to be reimbursed. Your reimbursement amount is based on the participating pharmacy's contracted rate **minus your co-payment** and will be subject to Plan rules and restrictions. **If you obtained a brand name drug that had a generic equivalent, then you will be responsible for paying the difference in total cost between the brand name drug and the generic drug in addition to the appropriate co-payment.** Reimbursement is based on a specific fee schedule, minus the appropriate co-payment, regardless of what the pharmacist's charges are. The same fee schedule is used to reimburse a participating pharmacy when a member uses his/her prescription drug card.

## Medicare-Eligible Retirees and the DC 37 Cultural Institutions Prescription Benefit (DC 37 Medicare Part D Retiree Plan)

**The DC 37 Medicare Part D Retiree Plan covers only Medicare-eligible retirees and their Medicare-eligible dependents.**

All Medicare eligible retirees and their Medicare-eligible dependents (except retirees/dependents enrolled in other Medicare Advantage Plans ("MAPs")) are enrolled automatically in the DC 37 Medicare Part D Retiree Plan. All participants are given the option to opt out of the DC 37 Medicare Part D Plan if they wish to participate in a Medicare Part D Plan of their own choosing.

Ninety (90) days before a retiree or Medicare eligible dependent reaches the age of sixty-five (65), a letter and an opt-out form will be sent to him/her. This letter will request that the retiree send in a copy of his/her Medicare card or provide his/her health insurance claim number and gives him/her the option

to opt out of the DC 37 Medicare Part D Plan if he/she wishes to be in a private plan of his/her own choosing. By law, a retiree cannot be in two Medicare Part D Plans, including MAPs at the same time. A retiree who is a member of one Medicare Plan will be disenrolled from all coverage (including medical coverage) provided by that plan, if he/she enrolls in a second Medicare Part D Plan.

Once the H&S Plan receives the retiree's Medicare information, it is forwarded to the vendor that administers the Medicare Part D benefit package so that the retiree can be enrolled. The vendor then sends a welcome package to the retiree which explains the benefit. Once the retiree is enrolled, he/she is sent a prescription drug card by the vendor.

Please note: If you are a retiree and you decide to enroll in an independent Medicare prescription drug plan or receive a prescription drug benefit through your enrollment in a Medicare Advantage Plan (doctor and hospital coverage) such as Secure Horizon/Oxford, **your Plan prescription drug benefit will be affected.** You will receive your prescription drug benefits through that program and will be responsible to pay any applicable premiums, deductibles or co-payments for that plan. These costs are not reimbursable by the Plan's prescription drug benefit.

### **The Preferred Products List**

The Plan has instituted a Preferred Products List, which identifies prescription drugs that can be used for virtually all illnesses and conditions and will meet the needs of all types of patients. The List was developed by a select group of physicians and pharmacists to ensure that all the drugs are therapeutically sound. The drugs on the list meet Federal standards for quality, strength, purity, effectiveness and safety as established by the FDA. Drugs on the preferred products list are available to you at a lower co-payment than other brand drugs. When there is no generic drug available, use a prescription that appears on the Preferred Products List. It will save money for you and the Plan.

### **Mail-Order Program**

The mail-order program is a voluntary program designed for participants who require maintenance-type medication. You will save money because you get a 90-day supply of medication for the cost of two (2) co-payments as opposed to a 90-day supply at a Retail 90 Rx pharmacy for three (3) co-payments. Please allow fourteen (14) days for delivery from the date you mail in the original prescription. Be sure to enclose a check or provide a credit card number to cover the cost and/or the copayments associated with the prescriptions you send to the Mail Service Program. Failure to provide a check or credit card number will delay your mail-order prescription until such information is provided. For additional information about the mail-order program, you can access the DC 37 website at [www.dc37.net](http://www.dc37.net) or contact the Plan's Inquiry Unit at 212-815-1234.

### **Annual Limit**

There is no annual dollar limit for the prescription drug benefit.

## Step Therapy Program (Rx Instep)

The Plan has instituted a mandatory Step Therapy program for certain drug categories, especially those used to treat certain ongoing medical conditions. This policy allows you and your family to receive the affordable treatment you need and helps the Plan contain the rising cost of prescription drug coverage.

The drug categories in the Step Therapy program include medications for cholesterol, high blood pressure, dermatitis and eczema, attention deficit hyperactivity disorder, asthma and allergy, depression, rheumatoid arthritis, diabetes,<sup>6</sup> pain and arthritis and ulcer and gastro-esophageal reflux disease.

Here's how the Step Therapy program works:

**Step One:** For those drug categories in the Step Therapy program, you are required to try one or more of the drugs in Step One before the Plan will cover you for drugs in Step Two. The Step One drugs (usually generics) covered by the Plan have been proven to be effective in treating the relevant medical condition. You will usually have the lowest co-payment for a Step One drug.

**Step Two:** If treatment with the required Step One drug(s) does not work for you, the patient can be given a more costly Step Two drug. Once you have notified the Plan and provided any required documentation, you will not need additional approval to fill the new prescription at the pharmacy because we will have a record of the use of the Step One drug. These Step Two drugs will often have higher co-payments.

If your doctor is prescribing a medication in a Step Therapy drug category for the first time, ask your doctor to prescribe a Step One medication. The Step Therapy program's medication list is available at the Plan's website, [www.dc37.net](http://www.dc37.net) or from the H&S Plan Office. If the drug does not work for you, you may call the H&S Plan Office at: 212-815-1608 and request that you be allowed to try another drug in the category. For certain drug categories (such as statins), before you become eligible for coverage of a Step Two drug, the Plan may require that you provide a note from your doctor or other evidence showing that the drug did not work for you. If after review, your prescription for a Step Two drug is denied by recommendation of the Plan's Medical Consultant, you have the right to appeal under the Plan's appeal process (first level is to the Administrator; if denied you may appeal to the Board of Trustees<sup>7</sup>).

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

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<sup>6</sup> See Important Note regarding diabetes coverage on p. 22.

<sup>7</sup> See page 45 for more information on appeals.

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

### **IMPORTANT NOTES**

1. For all active members, non-Medicare eligible retirees, and eligible dependents enrolled in the City of New York's Health Benefits Program, diabetes medication is provided by the various health plans as part of the basic benefit package.
2. For all active members, non-Medicare eligible retirees, and eligible dependents enrolled in the City of New York's Health Benefits Program, coverage for injectables and chemotherapy is provided by the PICA program.
3. For all Medicare eligible retirees and their Medicare eligible dependents, prescription drugs are provided through the DC 37 Medicare Part D Plan.

### **EXCLUSIONS/LIMITATIONS:**

#### **The Prescription Drug Benefit will not cover the cost of:**

- a. Drugs prescribed for a Participant who is confined to a rest home, nursing home, extended care facility, assisted living facility or similar care facility where such drugs are covered in whole or in part by a federal, state, or local program or other insurance. Where only a portion of the cost of such drug is covered by another plan or insurer, the remaining cost of such uncovered drug will be covered to the extent permitted under the Plan's prescription drug benefit. The Participant will be responsible for all applicable co-pays and applicable special shipping costs. Under no circumstances will the Plan cover the cost of drugs administered in a hospital to members and eligible dependents;
- b. Drugs prescribed for any condition covered by Workers' Compensation, No Fault Automobile Insurance, or in any situation where third-party medical insurance is available;
- c. Chemotherapy obtained by a non-Medicare-eligible member and/or eligible dependent, administered on an out-patient basis in a hospital, or administered in a doctor's office;
- d. Drugs including vitamins, foods and dietary supplements that may be purchased with or without a prescription;
- e. Drugs supplied by a treating physician;
- f. Investigational or experimental drugs;
- g. Over-the-counter drugs (drugs purchased with or without a prescription);
- h. Prescription medications that have over-the-counter counterparts;
- i. Appliances and all companion implements (devices), including syringes and needles for the administration of prescription drugs;
- j. Drugs prescribed for cosmetic purposes;
- k. Prescription drugs used for intravenous drug therapy, which are infused in the home (and any charge for the administration of home infusion of the drug);

- l. Immunization agents and biological sera;
- m. Refills of medication covered by the benefit described in this section in excess of eleven (11) 30-day refills in any 12-month period;
- n. Refills of maintenance drugs covered by the benefits described in this section in excess of three (3) 90-day supplies in any 12-month period filled at the Plan's mail-order program or a retail Rx Pharmacy;
- o. Diabetes medication for members and non-Medicare-eligible retirees and eligible dependents except as noted;
- p. Chemotherapy and related medication for members, non-Medicare-eligible retirees and eligible dependents enrolled in the City of New York's Health Benefits program except as noted;
- q. Injectable medication for members, non-Medicare-eligible retirees and eligible dependents enrolled in the City of New York's Health Benefits program except as noted;
- r. Certain ACA (Affordable Care Act) preventive meds. However, you may be eligible to receive these drugs at no cost via your health insurance plan.

**The Plan will limit the coverage and cost of certain drugs as follows:**

1. Coverage for the class of prescription drugs used to treat male sexual dysfunction will require pre-approval by the Plan for certain specified medical conditions and will have a 50% co-payment.
2. Coverage for the class of prescription drugs used to treat obesity will require pre-approval by the Plan and will have a 50% co-payment.

The above limits apply only to prescription drugs covered under the generics-based prescription benefit for active members and non-Medicare-eligible retirees. This does not apply to prescription drugs covered under the DC 37 Medicare Part D Retiree Plan.

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

**Improper use and/or abuse of the Prescription Drug Card add costs to the Plan. Members/Retirees who, through carelessness or negligence, allow their Drug Card to fall into the hands of unauthorized persons, whether known to them or not, will be held responsible for the misuse of the card that was entrusted to the member/retiree for his/her use and/or for the use of his/her eligible dependents. Such unauthorized or improper use can also result in the suspension of all your Plan benefits.**



## **DISABILITY INCOME BENEFIT**

### **(This benefit is available to actively working members only)**

The Disability Benefit helps to provide a regular income when sick leave, similar coverage, Sick Leave Grants (i.e., 3.5), donated or dedicated sick time, or employer disability benefits have been exhausted. It begins when you have used up all your sick leave, but not before the end of the eighth (8th) day of disability. However, if you are hospitalized, the Disability Benefit begins as soon as you have exhausted your sick leave.

Under the Plan, a covered full-time member is entitled to receive 66 2/3% of their weekly pay (calculated on a 7-day/week basis) up to a maximum of \$200 per week, for the period of the disability but not longer than twenty-six (26) weeks.

A covered part-time member is entitled to receive 66 2/3% of their weekly pay (calculated on a 7-day week basis) up to a maximum of \$98 per week for the period of the disability but not longer than thirteen (13) weeks.

Disability Benefits are paid only while the member has been seen by, and is under the care of, a licensed physician. You must be on an approved medical leave of absence in order to qualify for benefits except if you are a provisional employee who is ineligible to receive a medical leave of absence.

ALL DISABILITY CLAIMS MUST BE FILED WITHIN FIFTEEN (15) DAYS FROM THE ONSET OF DISABILITY REGARDLESS OF THE AMOUNT OF SICK DAYS, VACATION OR ANNUAL LEAVE DAYS YOU HAVE ACCUMULATED. Further documentation will be necessary to extend benefits for a maximum of twenty-six (26) weeks for full-time employees and thirteen (13) weeks for part-time employees. Members are reminded that they should still file a Disability Benefit application with the Plan Office, even though they do not qualify for Disability Benefits. This will allow the Plan to project coverage for other Health & Security Plan Benefits for the applicable period.

### **Recurring Disability**

If you become totally disabled and begin to receive benefits, return to work, and then become disabled again from the same or a related illness, the 26- or 13-week maximum will include all periods of disability caused by this same illness or accident. A maximum of one additional disability benefit up to twenty-six (26) weeks for full-time employees and thirteen (13) weeks for part-time employees will be paid for the same or related illness/condition provided the member meets all the medical requirements and has worked continuously for one (1) full year since the date the prior disability period ended.

If you are disabled and receive Disability Benefits for an illness and you incur a second illness during the same disability period, you are only entitled to the maximum of twenty-six (26) weeks for full-time employees and thirteen (13) weeks for part-time employees. This is deemed one period of disability, which is limited to one 26-week maximum benefit period.

Should you return to work and become disabled due to an unrelated illness or injury, you would be eligible for a new disability period provided that a claim form and accompanying medical statement is submitted.

**Disability Benefits are not paid for in the following circumstances:**

- periods of disability caused by cosmetic surgery;
- self-inflicted injuries;
- war-related disabilities;
- injuries received as a result of the commission of a crime;
- an illness or injury arising out of employment;
- a disability arising from peacetime military service;
- a disability associated with an act which the Trustees consider to be a wrongdoing that is equivalent to the commission of a crime;
- a disability caused by alcoholism or drug abuse is not covered unless you are in a hospital or being otherwise treated for it at an approved treatment center. A current listing of approved treatment centers is available by calling the Personal Service Unit, 212-815-1250.
- No Disability Benefits are paid while the employee is receiving or is eligible to receive **Workers' Compensation** payments. However, you are eligible for all other benefits under the Plan for a maximum of twenty-six (26) weeks for full-time employees or thirteen (13) weeks for part-time employees from the time you go off payroll. However, a member shall be entitled to receive payment of the relevant Disability benefit if the member applied for Workers' Compensation and received a letter from the City Law Department (or your Workers' Compensation carrier) stating that the case is being controverted. The member must show that he/she has exhausted sick time and has applied for and was rejected for paid sick leave (i.e., 3.5 and 7.2 of the City time and leave rules or similar provisions provided by other agencies). In such cases, the Plan will send a lien notice to the Workers' Compensation Board.
- No Disability Benefits are paid if the employee is receiving **Social Security Disability** payments or **Veteran's Administration** payments, which are equal to/or exceed the Disability Benefits provided by the Plan. However, if your Social Security Disability payments or Veteran's Administration payments are less than the payments that would be provided by the Plan, the Plan will make up the difference up to the maximum payable under the Plan.
- Lien Rights
- If an eligible member is entitled to receive Disability Benefits by reason of a disabling condition caused by an accidental injury and the eligible member has, or may have, a claim against a third party, the Plan may require as a condition to the payment of benefits:

- that the eligible member execute an assignment of any claims he/she may have against third parties or other entities on account of the accidental injury, which assignment shall act as a lien against the claim to be paid; and
- that the eligible member cooperate with the Plan in enforcing the said assignment and lien by, among other things, advising the Plan of all persons or entities against which he/she has a claim and otherwise assisting the Plan in protecting its assignment.

### **Medical Exams**

- The Plan regularly arranges to have members examined who are out more than the reasonable and customary disability recuperation period. If we ask that you be examined, this will be done at no cost to you. If such an examination is scheduled for you and you refuse or do not show up for it, Disability Benefits will stop. If your claim is pending, it will not be processed any further. If you make up the examination later, and benefits begin again, there will be no retroactive benefits payable. The time lost between the stopping of benefits and their restoration, or the period in which your application was pending for this re-examination, will be counted in the 26-week maximum period of payment and the cost of the missed examination will be deducted from the benefits payable.

**IF YOU HAVE BECOME DISABLED AND PLAN TO LEAVE THE METROPOLITAN AREA OF THE CITY OF NEW YORK BEFORE OR AFTER YOU FILE FOR DISABILITY BENEFITS, YOU MUST REPORT THIS TO THE PLAN OFFICE AT LEAST TWO (2) WEEKS BEFORE YOU LEAVE OR YOUR CLAIM WILL BE DISALLOWED OR PAYMENTS WILL BE DISCONTINUED.**

The Plan must withhold F.I.C.A. (Social Security) tax from Disability Benefits; therefore, this amount is deducted from your gross benefit check. Disability Benefits may also be subject to income tax, and your Agency must issue a W-2 form to each member who received Disability Benefits.

Information on filing Disability claims is on page 38.

## **SECOND SURGICAL CONSULTATION**

Much surgery is elective, that is, the operation is not required by a medical emergency. When to have the operation, or whether to have it at all, is often a matter of opinion. Recent studies have shown that many elective operations are done without real need. Prior to a surgery, you should discuss the operation with the surgeon and ask questions about what it entails, the risks and the fees involved.

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

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

**THIS BENEFIT IS AVAILABLE TO PARTICIPANTS REGARDLESS OF THE HEALTH INSURANCE CARRIER YOU ELECT.**

**THE SECOND SURGICAL OPINION MUST BE OBTAINED THROUGH THE DC 37 HEALTH & SECURITY PLAN'S SECOND SURGICAL CONSULTATION (212-815-1355) OR THROUGH NYC HEALTHLINE (800-521-9574).**

For information on how to get a Second Surgical Consultation, see page 37.

## DEATH BENEFIT

When a member who is an actively-working full-time employee dies, a Death Benefit of \$10,000 will be paid to his/her designated beneficiary(ies). When a member who is a part-time employee dies, a Death Benefit of \$6,000 will be paid to his/her designated beneficiary(ies). When a retiree dies, a Death Benefit of \$1,000 will be paid to his/her designated beneficiary(ies).<sup>8</sup>

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

The designation or change of beneficiary takes effect immediately upon receipt of the appropriate form by the Plan and shall operate as a revocation of any previous designation. Divorce from your spouse/domestic partner does NOT change your beneficiary designation. If you do not wish your former spouse/domestic partner to receive your death benefit, you must fill out a new beneficiary form.

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

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

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

All members are reminded that beneficiary designations are treated as confidential information, which will not be disclosed by the Plan unless authorized by the member or retiree, or required by law. Please note that the Plan cannot release the name of your beneficiary to you by phone or in writing. You can call the H&S Plan Office and request a change of beneficiary form or you can download the form from the website at [www.dc37.net](http://www.dc37.net). This form should be completed naming your current beneficiary of choice, signed, notarized and returned to the H&S Plan Office. Once the Plan has received this change of beneficiary form it will replace all previously submitted named beneficiaries.

*Please note that a representative appointed by Power of Attorney may not designate themselves as a beneficiary for the benefit.*

Except where a member retires and becomes eligible for the \$1,000 retiree Death Benefit, Coverage for the Death Benefit ends sixty (60) days from the date a member was on active payroll status unless the member is on an approved leave of absence, in which case the benefit ends six (6) months after the payroll date.

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<sup>8</sup> Retirees are not entitled to the Extended, Expanded or Enhanced Death benefits.

### **EXTENDED DEATH BENEFIT**

The extended death benefit (the death benefit available at the onset of the disability) is available to a member who is **under age 55** and is forced to leave employment because he/she becomes totally disabled.

In order to be eligible for this benefit, the member must meet the following conditions:

1. The member received the maximum Disability Benefit provided by the Plan;
2. The member is under age 55;
3. The member remained disabled until his/her death;
4. The member is uninsurable and unemployable;
5. The member is not receiving a pension from a current Employer; and,
6. The member qualifies for Social Security disability benefits.

If the member meets all of the above qualifications, upon his/her death, his/her beneficiaries will be entitled to receive the Death Benefit that was in effect at the time the disability benefits were exhausted.

Coverage for this benefit ends when the member ceases to be disabled, retires, reaches age 55, or the benefit is discontinued.

For information on filing a death benefit claim, see page 38.

### **EXPANDED DEATH BENEFIT**

The expanded death benefit is available to a member who is **age 55 or older** and is forced to leave employment because (s)he becomes totally disabled.

In order to be eligible for this benefit, the member must meet the following conditions:

1. The member received the maximum disability benefit provided by the Plan;
2. The member is 55 or older;
3. The member remains disabled until his/her death;
4. The member is uninsurable and unemployable;
5. The member is not receiving a pension from a current Employer; and
6. The member qualifies for Social Security disability benefits.

If the member meets all of the above qualifications, his/her beneficiaries will be entitled to receive an Expanded Death Benefit of \$1,500.

Coverage for this benefit ends three (3) years after the member first met all of the above conditions, or the benefit is discontinued.

### **ENHANCED EXPANDED DEATH BENEFIT**

If a member with ten (10) years of continuous employment qualifies for an expanded death benefit and is **over 55 and under 62**, s(he) will be eligible for a \$5,000 death benefit. All other components of the benefit remain in place.

**NOTE: All determinations as to total disability under the Extended Death Benefit and Expanded Death Benefit are made in the sole and absolute discretion of the Trustees.**

## **ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT**

If the member dies as a result of an accident, an additional Death Benefit of \$10,000 will be paid to his/her beneficiaries as an Accidental Death Benefit. In order to be covered for this Benefit, the death must occur within ninety (90) days from the date of the accident and be a result of injuries sustained in that accident. Pertinent documentation will be requested and reviewed by the H&S Plan Office before the benefit will be paid.

If the member loses a limb (hand or foot) or the sight of an eye as a result of an accident, (s)he will receive a benefit of \$5,000 for each lost limb or eye - but no more than a total of \$10,000 will be paid under this Benefit for a loss sustained in any one accident.

The loss of limb or eye sight must be the result of an accident, not of a disease, act of war, or injuries received during the member's commission of a crime.

### **Limitations of coverage:**

The **Accidental Death, Dismemberment and Loss of Sight Benefits** are not paid for any loss which is wholly or partly caused by or contributed to, directly or indirectly, by:

- a. Disease or bodily or mental illness or medical or surgical treatment thereof;
- b. Ptomaines or bacterial infections, except pyogenic infections occurring with and/or through an accidental wound;
- c. Suicide or intentionally self-inflicted injury, while sane or insane;
- d. Participation in, or as a consequence of having participated in, an act which would constitute the commission of a crime under the laws of the State of New York or the jurisdiction where the act occurred or an act which the Trustees consider to be a wrong-doing that is equivalent to the commission of a crime;
- e. War or any act of war, whether declared or undeclared or peacetime military service;
- f. Any injury arising out of, or in the course of, any employment for wage or profit where a benefit is payable on account thereof by the Employer and/or through a Workers' Compensation policy; or
- g. Consumption of alcohol or the use of any drug unless the use is upon the advice and prescription of a licensed medical or dental practitioner.

For information on filing Accidental Death, Dismemberment and Loss of Sight Benefit, see page 38.

## **AUDIOLOGY BENEFIT**

The Audiology Benefit which is operated by District Council DC37 Health and Security Plan is provided in response to the many members/retirees who suffer hearing loss problems and don't have ready access to affordable quality care.

This benefit is available to members and retirees **only** (not to eligible dependents) and only at the Health Center located at 115 Chambers Street, New York, (212) 791-2126. All services are provided by licensed, certified audiologists.

The Audiology Benefit includes a comprehensive audiologic evaluation that determines the type and degree of the hearing loss which is outlined as an audiogram. If the evaluation confirms a hearing deficiency, the member will be given the audiogram and report to be taken to an Ear, Nose and Throat ("ENT") specialist for either medical treatment or medical hearing aid clearance.

**The member/retiree must apply directly to his/her basic health insurance carrier for reimbursement of the Specialist's fee; it is not covered by the Audiology Benefit. Members/Retirees who have coverage through an HMO must follow the procedures established by his/her carrier for seeing a specialist.**

After seeing the ENT doctor and obtaining medical clearance for hearing aids, the member/retiree will be seen for a hearing aid evaluation. At that time, the Audiologist will review the types of hearing aids available to fit the member/retiree's hearing loss. If the member/retiree chooses basic digital hearing aids, he/she will receive a right and left hearing aid at no charge. (The two hearing aids must be received at the same time.) More advanced models are available at an additional cost. This amount is payable at the dispensing appointment.

The member/retiree will return for a hearing aid dispensing. The hearing aids will be programmed and dispensed with a 45-day trial period. The member/retiree is seen during the trial period for any adjustment necessary to ensure good benefit from the hearing aids.

Replacement batteries are not provided unless otherwise indicated. Aural rehabilitation is not provided by the Plan.

Appointments for the Audiology Center must be scheduled in advance. Call (212) 791-2126 to make an appointment.

### **SERVICES NOT PROVIDED BY THE AUDIOLOGY BENEFIT:**

1. Batteries will be provided with a hearing aid, but all future battery replacement will be the responsibility of the member/retiree.
2. Hearing Aid repairs (except those under the manufacturer's warranty) are not covered. The cost of repairs will be the responsibility of the member/retiree.



3. The cost associated with rehabilitation therapy needed to acclimate the user to the hearing aid will be the responsibility of the member/retiree.
4. The Plan will not service or honor claims for hearing aids obtained outside of the Audiology Center.
5. The benefit does not cover assistive listening devices.

Audiology Center is located at:

DC 37 Health Center  
115 Chambers Street  
New York, N.Y. 10007

**IF YOUR BASIC HEALTH INSURANCE COVERAGE PROVIDES REIMBURSEMENT FOR AN AUDIOLOGY BENEFIT, YOU WILL BE REQUIRED TO SIGN AN AUTHORIZATION FORM ALLOWING DISTRICT COUNCIL DC 37 HEALTH AND SECURITY PLAN TO FILE A CLAIM WITH YOUR INSURANCE CARRIER.**

## PERSONAL SERVICE UNIT

Available to all members, retirees and eligible dependents.

Everyone has problems from time to time, and it's alright to seek help for them.

Personal and family concerns, alcoholism and drug abuse, financial hardships, physical illness and difficulties with children are examples of some concerns that can cause a crisis that may require assistance.

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

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

### WHEN DO YOU NEED PSU?

#### 1. Job Jeopardy (available to active members):

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

#### 2. Personal and Family Problems:

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

Other problems that PSU can help you with include:

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

### WHAT ARE THE SERVICES OFFERED?

#### 1. Referrals:

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

## **2. Community Resource Information:**

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

## **3. Individual Counseling:**

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

## **4. Group Counseling:**

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

## **5. Workshops and Conferences:**

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

- Pre-Retirement Planning Workshops.
- Stress Management Workshops.

## **6. Outreach Program:**

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

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

## **HOW TO CONTACT PSU SCREENING:**

Call PSU at: (212) 815-1260 Monday - Friday 9:00 a.m.-1:00 p.m. If they are busy providing services to other participants, their telephones will be answered by an answering machine which will advise the caller that all the lines are busy. You may have to call a number of times before getting a social worker due to the large volume of calls coming into the unit.

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

## **WHAT TO EXPECT:**

You should be prepared to give a brief description of your problem, letting the social worker know who referred you to PSU and if the problem is job related. The social worker will then ask you a number of questions relating to your job, family and income. This information is for purposes of planning services for the membership. Please understand that the Plan may not cover certain services that are referred to you by PSU.

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

## **HEALTH AND PENSION SERVICES**

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

### **Health Insurance:**

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

The Unit will explain the benefits available under the City's Basic Health Insurance Plans, coverage available upon retirement and Medicare. If a member or dependent loses City coverage, the Unit will provide assistance in obtaining continued coverage through COBRA.

### **Pension:**

Another service provided by the Unit is pension counseling. Counselors are available, by appointment, to explain pension options including survivor benefits and to provide an overview of how to retire and obtain benefits upon retirement. It is advised that members make an appointment at least six (6) months prior to the planned retirement date.

In addition, the Unit advises members about disability pensions, including eligibility requirements and the steps necessary to protect the member from losing pension benefits.

You can visit or write the Health and Pension Unit at:  
125 Barclay Street, New York, NY, 10007  
Room 314, or call the Unit at (212) 815-1200.

## **SURVIVOR BENEFIT**

Upon the death of a covered member/retiree, the surviving eligible dependents are provided with 12 months of COBRA (the Consolidated Omnibus Budget Reconciliation Act) continuation coverage (both Core & Non-Core benefit) at no charge. This allows the eligible dependent to utilize Plan benefits for a period of twelve (12) months measured from the member/retiree's date of death. In addition, during this 12-month period, surviving dependents are also eligible for any other Health & Security benefits that they were eligible for prior to the member's death.

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

If the eligible dependent wishes to continue these benefits after the initial 12-month period for a maximum additional period of twenty-four (24) months, they must complete a COBRA Election Form and submit it to the Plan within ninety (90) days of the date that the initial 12-month period ends, indicating the level of coverage that the surviving dependent wishes to receive during the remaining 24-month period. Surviving dependents will be responsible to pay 102% of the cost of that coverage as described on the COBRA Form. For COBRA forms and rates, please contact the Inquiry Unit.

## **ANNUAL MEDICARE PART B REIMBURSEMENT DECISION**

Although not a permanent Plan benefit, the Trustees of the Plan have, from time-to-time, reimbursed eligible retirees for the premiums paid to their Medicare Part “B” insurance. The Trustees reserve the right to determine whether or not to continue this practice, as well as the exclusive right to determine when to pay, and the amount of, any such reimbursement. As with all other Plan benefits, the Trustees reserve the right, in their sole and absolute discretion, to amend, modify or terminate this (or any other) benefit available under the Plan.

In any year that the Trustees vote to reimburse eligible retirees for Medicare Part B premiums, the Plan will send a letter with an application form to each affected eligible retiree. Upon receipt of the letter, those retirees will be requested to promptly complete the application form, attach the form SSA 1099 you received from the Social Security Administration, and return it to the Plan. If you have any questions, please call the Inquiry Unit at (212) 815-1234.

## SUMMARY: HOW TO OBTAIN BENEFITS

### **YOU MUST FILE AN ENROLLMENT FORM WITH THE DC 37 CULTURAL INSTITUTIONS HEALTH & SECURITY PLAN TRUST.**

Before you can file a claim for any benefit in this booklet the Plan must know who you are and whether you are covered. Filing an Enrollment Form is the first step in receiving benefits.

**If you or one of your eligible dependents have a change of name or address, or if a death, marriage, domestic partnership, birth, court order, adoption, divorce, separation or dissolution of domestic partnership has changed the individuals in your family who are eligible for benefits, the Plan must be told of the changes.**

See page 5 for more information about enrollment and change of status.

In order to receive a benefit or obtain reimbursement for benefit expenses incurred, it is necessary to file the appropriate application or claim form with the H&S Plan Office.

Here's how to apply for your benefits: All claim forms and participating provider listings are available from the H&S Plan Office or from the website. Call the Inquiry Unit forms line at (212) 815-1531. Detailed benefit information on eligibility and the status of claims you have filed is available by calling the Inquiry Unit's information line at 212-815-1234.

In order to expedite claims processing, send completed claims to the H&S Plan Office at 125 Barclay Street, New York, NY 10007. Please send claims to the attention of the relevant unit (e.g. "Attn: Dental Benefit.")

**Second Surgical Consultation:** Call the Plan at (212) 815-1355 regarding this benefit.

**Dental Benefit:** After any dental work or course of treatment has been completed, you and your dentist must fill out a dental benefit claim form. Only American Dental Association claims forms will be accepted. For expedited claims processing, providers may also submit claims electronically at: <https://www.swcureedi.com/SecureTrack/>. All dental claims must be filed within ninety (90) days after the work is completed. Orthodontic claims may be filed quarterly. Please see the dental section for pre-authorization requirements. See page 10 for more information about the dental benefit.

**Prescription Drug Benefit:** If you use a Participating Pharmacist, bring your Prescription Drug Card to the pharmacy. If you do not use the Prescription Drug Card, you and the pharmacist must fill out the direct reimbursement claim form. The completed direct reimbursement claim form must be filed within thirty (30) days after you have paid for the drugs. See page 18 for more information about the Prescription Drug Benefit.

**Vision Care/Optical Benefit:** If you use a Participating Optometrist or Optician, all you need is a Voucher from the H&S Plan Office. If you do not use a Voucher, you and the Optometrist or Optician must fill out a direct

reimbursement form that must be filed within thirty (30) days after you have paid for your glasses. See page 16 for more information about the Vision Care/Optical Benefit.

**Disability Income Benefit:** You must file the completed Disability claim form no later than fifteen (15) days after your disability begins, regardless of accumulated sick, vacation, or annual leave time. See page 24 for more information about the Disability Benefit.

**Death Benefit:** The H&S Plan Office should be notified of the death of a covered member by phone or letter. The appropriate claim forms will be sent to the named beneficiary. If a member/retiree is not survived by any beneficiaries or has failed to name any beneficiaries, then the benefit will be paid according to the rules and regulations of the Plan. These forms must be returned to the Plan with a certified death certificate within one (1) year of the death. See page 28 for more information about the Death Benefit.

**Accidental Death, Dismemberment and Loss of Sight Benefit:** The form must be completed by a doctor and filed within thirty (30) days of the death or loss of sight or limb. See page 30 for more information about the Accidental Death, Dismemberment and Loss of Sight Benefit.

**Audiology Benefit:** Call (212) 791-2126 to make an appointment at the Health Center located at 115 Chambers Street, New York, New York 10007. See page 31 for more information about the Audiology Benefit.

**Personal Services Unit (PSU):** Call PSU at: (212) 815-1260, Monday - Friday 9:00 a.m. - 1:00 p.m. with questions or to make an appointment. See page 33 for more information about the Personal Services Unit.

**Members are reminded that claims must be filed in a timely manner. If the claim is filed late, a written excuse for the late filing must be submitted before the claim will be considered for payment. The Plan cannot and will not pay any claim, regardless of excuse, if the claim is filed after the deadline. Remember: You (not your health care provider) are responsible for filing the claim.**

## **PART III: EDUCATION FUND BENEFIT**

### **(Available to regular full-time or part-time active salaried staff members only)**

For over 40 years, the mission of the Education Fund has been to provide members the opportunity to enhance their skills and attain knowledge to create career pathways or promote personal growth and development. Over the years the Fund has grown from a High School Equivalency program to one that offers a wide range of courses, training and workshops.

As the educational and career needs of our members continue to evolve, the Fund's program offerings continue to grow. The Education Fund offers courses in technology, programs where members can earn college credit, an Allied Health Program, Career Development classes, and a comprehensive Adult Basic Education Program for members who want to prepare for college entrance or take the high school equivalency examination. In addition, members can seek educational support through literacy programs, learning labs, and guidance from a team of education/career counselors. Sessions in math, reading and writing can also help members with professional and personal growth.

### **Eligibility**

The Education Fund Benefit is available to all eligible active members of District Council 37. Education Fund benefits are not available to retirees or dependents (including a spouse/domestic partner, dependent children or other family members).

### **What does it Cost?**

All Educational Fund programs are offered at no cost to the member. However, the Fund does not cover any costs associated with licensing, examination or certification fees.

### **Locations**

While most programs are held at DC 37 headquarters (125 Barclay Street, New York, New York 10007), there are Adult Learning Centers in designated locations throughout the city. Each Adult Learning Center provides both group and individualized instruction to those members who are preparing to take college entrance, ACT, GED or Civil Services exams. For a complete and up to date listing of course offerings, please call the Education Fund office at (212) 815-1700 to request a brochure or go to the DC 37 website at [www.dc37.net](http://www.dc37.net) and click on to the Education Fund link to download an application.

## **EDUCATION FUND COUNSELING SERVICE**

Returning to school as an adult can be a challenge, yet many adults do so every day. At the Education Fund, specially-trained Career Counselors are available to help members meet the challenges working adults face, as well as explore their educational goals.



Career Counselors also provide information and conduct workshops on study skills, time management, career planning, financial aid, college entrance and much more.

If you have any questions about improving your education or career, even if you are not currently enrolled in an Education Fund course, you may call for an appointment to meet with a counselor.

Let the Education Fund help you by providing the information you may need to design your educational future.

Call (212) 815-1695 for an appointment.

### **DC 37 CORNELL/CUNY CERTIFICATE PROGRAM**

District Council 37 Education Fund in partnership with Cornell University's ILR and CUNY's Murphy Institute is offering a Certificate in Public Labor Relations. This 16-credit undergraduate certificate program offers a comprehensive overview of labor relations in the public sector.

Classes are open to eligible members of DC 37. High school transcripts/records or proof of GED are required for admission.

Classes are held on scheduled weekday evenings from 6:00 p.m.-9:15 p.m. The program is comprised of four courses. Each course meets once a week for a 15-week semester.

Tuition and fees (excluding the onetime \$70.00 admission fee and books) are covered for eligible DC 37 members.

The program is held at the Cornell Conference Center, 16 E. 34th Street, 6th floor.

To learn more about the program, please call the Education Fund at (212) 815-1700.

### **CAREER DEVELOPMENT**

The Education Fund conducts test preparation classes for some Civil Service exams and career-related licensing exams.

The Career Development staff also assists DC 37's Locals in developing education programs designed to enhance the skills of specific groups of workers.

For up-to-date information on test preparation courses, call the Education Fund at (212) 815-1700.

### **TUITION REIMBURSEMENT**

The Education Fund administers a Tuition Reimbursement Program through which eligible members can receive up to \$800 per calendar year. Eligible members must attend an accredited college, university or other institution of learning and can apply for reimbursement for courses on the undergraduate, graduate and post-graduate levels. Members may also be reimbursed for online courses and Continuing Education courses taken through an accredited school. The Tuition Reimbursement Program will only provide reimbursement for tuition and/or registration fees paid out-of-pocket by members, up to a

maximum of \$800 per calendar year. Tuition Reimbursement does not cover the cost of classes taken through the union's Saturday Activity Program.

To apply for tuition reimbursement, members must submit an application within one hundred twenty (120) days from the last day of class and have a passing grade of C or better. Members may also submit a certificate of successful completion and a detailed bursar's receipt with proof of payment. If applicable, a financial aid statement and proof of any tuition assistance you may have received from the Cultural Institutions for the same term may be required.

Tuition reimbursement payments cannot exceed the \$800 maximum per calendar year. Members may apply each year.

All Education Fund benefits, including Tuition Reimbursement, are available to eligible members only and are not available to a member's spouse/ domestic partner, dependent children or other family members.

For additional information or for a tuition reimbursement application, call (212) 815-1700 or go to the DC 37 website at [www.dc37.net](http://www.dc37.net) and click on to the Education Fund link to download an application for Tuition Reimbursement.

### **BERNIE RIFKIN SOLIDARITY LIBRARY**

The Education Fund Library offers a circulating collection of popular materials that can be borrowed for up to twenty-eight (28) days and a basic reference collection. Whether you're interested in books on popular fiction, current events, history, women's, Black or Latin studies, biographies, science, art, psychology, or DVDs, the Education Fund Library will have something for you. In addition, there are four special collections: Harry Gray Memorial Labor Collection, which is a popular selection of books on workers, unions and collective bargaining donated by Local 372; a New York City Collection consisting of books of all types on the history, economy and culture of New York City donated by locals and staff of DC 37 in memory of June Ringel; Paul Greene Memorial Collection which is a selection of films and literature from the American Experience; and a Basic Skills Collection on reading and writing skills, math, GED and ESL. The Education Fund Library also hosts film presentations, exhibits and book discussions throughout the year.

You can visit the library at Union Headquarters, 125 Barclay Street, 2nd Floor, Room 211, or you may telephone at (212) 815-1699. Please note that library hours are subject to change.

## PART IV: GENERAL BENEFITS INFORMATION

### INITIAL CLAIMS AND APPEALS PROCESS AND TIME FRAMES

For more information on how to submit claims, see page 37.

#### Timing of Claims Submissions by Participants

To be eligible for reimbursement, all claims must be submitted on the appropriate forms within the below timeframes:

- Drug and Optical benefits claims must be submitted within thirty (30) days of the date of service.
- Dental Benefit claims must be submitted within ninety (90) days of service.
- Death Benefit claims must be submitted within one (1) year of the date of death.
- Claims for Disability Income Benefits, must be submitted within fifteen (15) days after the event, medical or accidental, which gives rise to the disability.

#### Claims under the Dental Benefit, Optical Benefit, Audiology Benefit and Prescription Drug Benefit

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

#### Claims Requiring Pre-Certification

For claims requiring pre-certification, the Participant will be notified of the Plan's benefit determination (whether adverse or not) within a reasonable period, but not later than fifteen (15) days after receipt of the claim. The 15-day period may be extended for up to fifteen (15) days for matters beyond the Plan's control if, before the end of the initial 15-day period, the Plan notifies the Participant of the reasons for the extension and of the date by which the Plan expects to render a decision. If the extension is needed because the Participant did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have forty-five (45) days from receipt of the notice to provide the specified information. If the claim is improperly filed, the Plan will provide notice of the failure within five (5) days.

#### Claims Involving Urgent Care which Require Pre-Certification

A "claim involving urgent care" is any claim for care which requires pre-certification and with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical

condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim involves urgent care will be determined by the Plan, except that any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of the definition above, shall be treated as a "claim involving urgent care."

If your pre-certification claim is determined by the Plan to be a claim involving urgent care, notice of the Plan's decision will be provided to you as soon as possible but no later than seventy-two (72) hours after receipt of your claim by the Claims Administrator. The exception is if you do not provide sufficient information to decide your claim. In that case, notice requesting specific additional information will be provided to you within twenty-four (24) hours of receipt of your claim. The Plan's decision regarding your claim will then be issued as soon as possible but no later than forty-eight (48) hours after the earlier of:

- the Plan's receipt of the requested information or
- the expiration of the time period set by the Plan for you to provide the requested information (at least forty-eight (48) hours).

Note: in the case of claims involving urgent care, benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within three (3) days after the oral notice.

Any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the Plan must be decided as soon as possible. This takes into account the medical exigencies, and notification must be provided to the claimant within twenty-four (24) hours after receipt of the claim, when the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If such a request is not made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes (as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt).

### **Claims for Disability Benefit**

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

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

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

**Note:** For any category of benefit, if an extension is needed because the Participant did not submit the information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to the Participant until the earlier of: (i) the date on which the Participant responds to the Health & Security Plan's request for additional information, or (ii) expiration of the 45-day period within which the Participant must provide the requested additional information.

### **Notice of Initial Adverse Benefit Determination**

After an initial adverse benefit determination (in whole or in part), notification of such determination will be provided containing the following information:

1. The specific reasons for the adverse benefit determination;
2. Reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;
3. A description of any additional material or information necessary for the Participant to complete the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures;
5. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
6. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the Plan's terms to the Participant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.
7. Claims Involving urgent care will have a description of applicable expedited appeal procedures.

## **APPEALS PROCESS**

Some benefits are denied, in whole or in part, either because of improper filing, because your benefit claim is not covered, or because of ineligibility for the benefit. If you feel that your benefit is denied in error, you may want to appeal the denial.

The Plan provides for a two-level process of appeals of adverse benefit determinations. The first level is to the Administrator of the DC 37 Cultural Institutions Health & Security Plan and the second level is to the Board of Trustees.

### **First Level: Administrative Appeals**

If the Participant is not satisfied with the reason or reasons why the claim was initially denied, then the Participant should first appeal to the Administrator of the Cultural Institutions Health & Security Plan. The Participant must write to:

Administrator of the District Council 37  
Cultural Institutions Health & Security Plan,  
125 Barclay Street, New York, New York 10007

within one hundred eighty (180) days after receiving the Plan's initial adverse benefit determination.

### **Second Level: Board of Trustees Appeals**

If the Participant's appeal to the Administrator is denied and the Participant is not satisfied with the reason or reasons for denial, then the Participant may appeal to the Board of Trustees. The Participant must write to:

Board of Trustees of the District Council 37  
Cultural Institutions Health & Security Plan,  
125 Barclay Street, New York, New York 10007

within sixty (60) days after receiving the Plan's first level appeal determination.

### **Appeals Rules and Requirements**

At each level of appeal, if the Participant has chosen a representative in making the appeal, then the letter must be filed with the Plan stating that the Participant has authorized the representative to represent the Participant with respect to the appeal. The Participant must sign the letter.

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

In addition, in regard to all appeals other than those involving the Death Benefit, Accidental Death, Dismemberment or Loss of Sight Benefit, or Disability Benefit:

- (1) the review will not afford deference to the initial adverse benefit determination nor the first level appeal determination (if applicable) and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual;
- (2) insofar as the adverse benefit determination is based on medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
- (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

#### **What Must Be Included in a Participant's Appeal Letter**

- Clearly indicate that the Participant is appealing the decision;
- if applicable: a statement, signed by the Participant, indicating the assignment of any representative;
- the type or nature of the claim;
- the reason it was denied;
- the reasons why the claimant believes the claim should be accepted; and
- any other information that the claimant feels should be considered on the appeal. This appeal must be filed within one hundred eighty (180) days from receipt of the rejection notice.

Note: if your claim involves urgent care, your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method.

#### **NOTIFICATION OF APPEALS DECISIONS**

##### **Time Frames For Administrative Appeals Decisions**

- **Dental Service or Prescription Drug Benefit Requiring Pre-Certifications:**

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

- **Urgent Care Claims:**

The participant will be notified as soon as possible taking into account the medical urgency involved, but not later than thirty-six (36) hours after receipt of the appeal.

- **All Other Claims:**

The Participant will be notified of the Administrator's decision within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

**Content of Administrative Appeals Decisions**

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

1. The specific reasons for the adverse benefit determination;
2. Reference to specific Plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
4. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request; and
5. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request; and
6. A description of the Plan's appeal procedure and the time limits applicable to such procedures.

**Time Frames for Board of Trustee Appeals (except Urgent Care Claims)**

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

Note: For urgent care claims, the participant will be notified of the board's decision as soon as possible taking into account the medical urgency involved, but not later than thirty (36) hours after receipt of the second appeal.



### **Content of Board of Trustee Appeals Decisions**

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

1. The specific reasons for the adverse benefit determination;
2. Reference to specific Plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
4. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request; and
5. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

### **Board of Trustees decisions are Final and Binding**

The Trustees' final decision with respect to their review of the Participant's appeal will be final and binding upon the claimant because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan.

## **GENERAL INFORMATION WITH RESPECT TO PLAN ADMINISTRATION**

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

The Benefits Fund uses the money it receives to fund, in its discretion: the DC 37 Health & Security Plan and the DC 37 Education Fund, which, in turn, provide you with the benefits described in this booklet. Each of the Funds is a legal entity, separate and distinct from the Union.

### **PLAN DOCUMENTS**

This Booklet is designed to explain the benefits provided by the Plans. However, the Plans are administered in accordance with the Health & Security Plan Document; and the Education Fund Plan Document (“Document(s)”). This Summary Plan shall not, in any manner or provision, be inconsistent with or contradict any aspect of the said Documents. In such event the provisions of said Documents shall govern and apply as if a part of this Summary. Under no circumstances shall the Plans be liable for any inconsistencies or contradictions between this Summary Plan Description and the Documents.

Upon written request, the Administrator of the appropriate Plan shall make available for inspection the various documents which govern the structure of the Plan. These documents may be examined by you at the Plan’s office during the regular business hours of the day (9 a.m. to 5 p.m.) by an appointment made on receipt of your written request. In addition, the Plan will make copies of any of these documents available for your use upon payment by you of the reasonable costs of duplicating the ones you may select. Examples of the costs involved would be as follows: The Health & Security Plan Document \$5 (at the Plan office). Education Fund Plan Document \$1 (at the Plan office). Printed and bound Summary of the Plans (this booklet) no charge. Photocopies or otherwise reproduced copy of Trust Instrument, Collective Bargaining Agreement, etc., 10 cents per page.

### **ADMINISTRATION**

The day-to-day operations of the Plan and the Education Fund are managed by an Administrator appointed by the Trustees. The Administrator is also the agent for service of legal process against the Plan for benefits. The address for service of process is:

Administrator  
DC 37 Cultural Institutions Health & Security Plan  
125 Barclay Street  
New York, NY 10007

Service of process may also be made upon any Plan Trustee

## **PLAN AMENDMENT**

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

## **INTERPRETATION**

The Board of Trustees has the exclusive right and power, in their sole and absolute discretion, to interpret the Plan document and to decide all matters arising thereunder. Such decisions would include, but would not be limited to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Trustees and/or their duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan. The Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Plan.

## **FISCAL YEAR**

The Plans currently file reports with the Internal Revenue Service, the Comptroller's Office, and other governmental agencies on a fiscal year basis which begins the first day of July of each year and ends the thirtieth day of the following June. The books and records of the Plans are kept on the same fiscal year basis. These books and records are annually audited by independent certified public accountants and reports of these audits are submitted to the Comptroller of the City of New York.

## **QUESTIONS**

From time to time you may have questions concerning your coverage or the present status of a benefit which you have filed for. Under those circumstances, you should contact the Inquiry Unit by writing to them at the Plan address or by telephone at 212-815-1234. In the event they cannot answer your questions, they will put you in contact with the person or persons who can do so.

The Employer Identification Number issued to the Trustees is 13-3075750. The Plan Number assigned to the Plan is 501.

## **REFUND DUE STATUS**

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

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

### **Procedure for Invoking Refund Due Status**

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

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

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

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

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

Any member placed in “Refund Due” status has the right to appeal by filing a written appeal to the Trustees within thirty (30) days of receipt of the notice of being placed in “Refund Due” status. An appeal to the Trustees is the final appeal of being placed in “Refund Due” status. The determination made by the Trustees will be given to the Plan Administrator, who will notify the member in writing.

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

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

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

## PART V: ERISA AND OTHER LAWS

### YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA).

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

#### **Receive Information About Your Plan and Benefits:**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's Annual Financial Report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

#### **Continue Group Health Plan Coverage:**

Continue health care coverage for yourself or eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

#### **Notices**

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

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

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

The Plan will make the decision as to whether the dental or vision service:

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

## **Prudent Actions By Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the material and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal Court following exhaustion of the appeals process of the Plan. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the persons you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## CONTINUATION COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) requires the City and union welfare funds to offer employees and their families the opportunity for a temporary extension of group health and welfare fund coverage (called “continuation coverage”) at 102% of the group rates, in certain instances where benefits under either City basic or the applicable welfare fund would be reduced or terminated.

**Note: You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 for more information.**

The benefits available for continuation coverage are:

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

To continue basic health insurance under the COBRA law, members should contact their personnel office.

For information about qualifying events, or to request an application and rate chart for the Plan benefits available through COBRA, please call the Health and Security Plan Office at 212-815-1239.

### Continuation coverage rights under COBRA

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You or your eligible dependents could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

If you are the spouse/domestic partner of a member/retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse/domestic partner dies;
2. Your spouse/domestic partner’s hours of employment are reduced;
3. Your spouse/domestic partner’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse/domestic partner becomes enrolled in Medicare (Part A, Part B, or both); or



5. You become divorced or legally separated from your spouse/domestic partner.

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

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

Children who are born to or placed for adoption with a covered employee during the period of the employee’s continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan’s rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child’s birth or adoption).

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

#### **Notice of COBRA Qualifying Event.**

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

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

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

### **How is COBRA continuation coverage provided?**

Once the Plan Administrator is notified that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has sixty (60) days from the later of (i) the date of the loss of coverage because of the qualifying event, or (ii) the date of the notice of the right to elect COBRA continuation coverage.

For each qualified beneficiary who elects COBRA coverage, coverage will begin on the date that Plan coverage would otherwise have been lost. If you timely elect (and pay for) continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If you do not timely elect (and pay for) continuation coverage, your group health coverage under the Plan will end.

### **Duration of COBRA Continuation Coverage**

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

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

#### **(1) Disability Extension of Continuation Coverage**

The 18-month period of COBRA continuation coverage may be extended for up to an additional eleven (11) months (for a total of up to twenty-nine (29) months of continuation coverage) if you or any family member covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first sixty (60) days of COBRA continuation

coverage, provided that you notify the COBRA Administrator of the SSA determination within sixty (60) days of the date of the determination and before the end of the initial eighteen (18) month continuation coverage period. The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to this notice requirement. Notice must be sent to the COBRA Administrator.

### **(2) Second Qualifying Event Extension of Continuation Coverage**

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

### **Early Termination of Continuation Coverage**

The law provides that continuation coverage may be cut short prior to the expiration of the applicable 18- 29- or 36-month period for any of the following five (5) reasons:

1. Premiums are not paid in full on a timely basis;
2. The employer ceases to maintain any group health plan;
3. A qualified beneficiary begins coverage under another group health plan after electing continuation coverage, as long as that plan doesn't impose an exclusion or limitation affecting a preexisting condition of the qualified beneficiary;
4. A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
5. A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

### **If You Have Questions**

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

### **Keep the Plan Informed of Changes**

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

## PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

- The Board understands that the Plan will only disclose your protected health information to the Board for the Board’s use in Plan administrative functions and such disclosures explained in the Notice of Privacy Practices that will be distributed to you by the Plan. In all cases, the Board will receive only the minimum necessary amount of protected health information necessary for the Board to perform Plan administrative functions. Such Plan administrative functions may include assisting participants in filing claims for benefits under the Plan, or filing an appeal of a denied claim with the appeals committee. The Board may also receive protected health information as necessary for the Board to perform its fiduciary and administrative duties.

- The Board will not use or disclose your protected health information for any reason other than for the Plan's administrative functions, as otherwise expressly permitted by the Plan Documents, as required by law, or if the Board has your written authorization.
- The Board will not use or disclose protected health information for employment-related actions or decisions or in connection with any pension or other employee benefit plan sponsored by the Board, unless it receives your express written authorization.
- If the Board discloses to any of its agents or subcontractors any of your protected health information that it receives from the Plan, the Board will require the agent or subcontractor to agree to the same restrictions that govern the Board's use or disclosure of your protected health information under the Plan Documents.
- The Board will promptly report to the Plan's Privacy Officer if it becomes aware of any use or disclosure of your protected health information that is inconsistent with the uses and disclosures allowed under the Plan documents.
- The Board will allow you or the Plan to inspect and copy your protected health information that is in its custody and control to the extent required of the Plan under HIPAA. (You should review the Notice of Privacy Practices to learn more about your rights to receive copies of your health information maintained by the Plan.)
- The Board will make your protected health information available to you, or to the Plan in order to allow you or the Plan to amend the information, to the extent required under HIPAA, and the Board will incorporate any such amendments that the Plan has accepted in accordance with HIPAA. (You should review the Notice of the Privacy Practices to learn more about your rights to request an amendment to your protected health information maintained by the Plan.)
- The Board will keep a written record of certain types of disclosures that it makes, if any, of your protected health information for reasons other than for your medical treatment, payment for that medical treatment, or health care operations, or with your written permission. This written disclosure record will include those types of disclosures made during at least the previous six (6) years, except only disclosures made after April 14, 2003 must be listed. The Board will make this disclosure record available to the Plan so that the Plan can provide you, upon request, with a copy of that list of disclosures. (You should review the Notice of Privacy Practices to learn more about your rights to request a log of certain types of disclosures of your protected health information made by the Plan.)
- The Board will make available its internal practices, books and records relating to its use and disclosure of protected health information, that it receives in its capacity as the sponsor of the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA.

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

Only the DC 37 Health & Security Plan's employees may be given access to protected health information received from the Plan on behalf of the Board, and these employees or workforce may only use your protected health information solely for the purpose set forth in the Plan Documents.

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

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

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

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;
- Ensure that adequate separation required to exist between the Plan and the Board is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect that information;

- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operation in its information system; and
- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.



**DISTRICT COUNCIL 37 CULTURAL INSTITUTIONS  
HEALTH & SECURITY PLAN TRUST  
NOTICE OF PRIVACY PRACTICES**

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

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

**Privacy officer:**  
Audrey A. Browne, Esq.  
(212) 815-1305  
125 Barclay Street,  
New York, NY 10007  
*abrowne@dc37.net*

**Effective Date: 2015**

*The DC 37 Cultural Institutions Health & Security Plan Trust (the “Plan”) is required by law to put in place reasonable measures that protect the privacy of your health information (“individually identifiable health information”) that is transmitted or maintained by the Plan in any form. This health information is considered protected health information (“PHI”). The Plan also is required to give you this notice of its legal duties and privacy practices related to your PHI. It is required to abide by the terms of this notice as currently in effect. The Plan has designated itself as a hybrid entity. As a hybrid entity, all of the Plan’s functions are covered functions that will comply with the federal regulations commonly referred to as HIPAA’s privacy rules. (HIPAA is the Health Insurance Portability and Accountability Act.)*

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

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

## **YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.**

### **OVERVIEW**

#### **Your Rights**

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **Your Choices**

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

#### **Our Uses and Disclosures**

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal actions

### **A CLOSER LOOK**

#### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within thirty (30) days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six (6) years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months.

#### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 45.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence

Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways:

#### Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

#### Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

#### Pay for your health services

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

## **Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

## **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

## **Do research**

We can use or share your information for health research.

## **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

## **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## **Address workers' compensation, law enforcement and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services

## **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Note: New York State Public Health Law 27-f creates a higher standard for protection of HIV related information.**

Generally a provider may not disclose any HIV-related information about any protected individual, with certain exceptions made for:

- Proper consent
- Health care providers & facilities
- Internal communications (need-to-know)
- HIV/AIDS case reporting
- Contact (partner) notification
- Parents & legal guardians (very limited)
- Court order

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

### **For more information see:**

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **CHANGES TO THE TERMS OF THIS NOTICE**

**We can change the terms of this Notice of Privacy Practices, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.**

## OTHER LAWS AND REGULATIONS

### **Qualified Medical Child Support Order (QMCSO)**

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

### **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires that health plans offer continuous coverage for up to 24 months to persons who are absent due to military service. The health plan may not require the person to pay any more than the employee share for that coverage if the period of military service does not exceed 31 days. If the period extends beyond 31 days, the employee may be required to pay not more than 102 percent of the full premium under the plan.

THE FOREGOING EXPLANATION OF THE PLAN IS NO MORE THAN A VERY GENERAL STATEMENT OF THE MOST IMPORTANT PROVISIONS OF THE PLAN. NO GENERAL STATEMENT SUCH AS THIS CAN ADEQUATELY REFLECT ALL OF THE DETAILS OF THE PLAN. NOTHING IN THIS STATEMENT IS MEANT TO INTERPRET, EXTEND OR CHANGE IN ANY WAY THE PROVISIONS OF THE PLAN. THEREFORE, YOUR RIGHTS CAN ONLY BE DETERMINED BY CONSULTING THE ACTUAL TEXT OF THE PLAN DOCUMENTS, WHICH ARE ON FILE WITH THE H&S PLAN OFFICE.



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