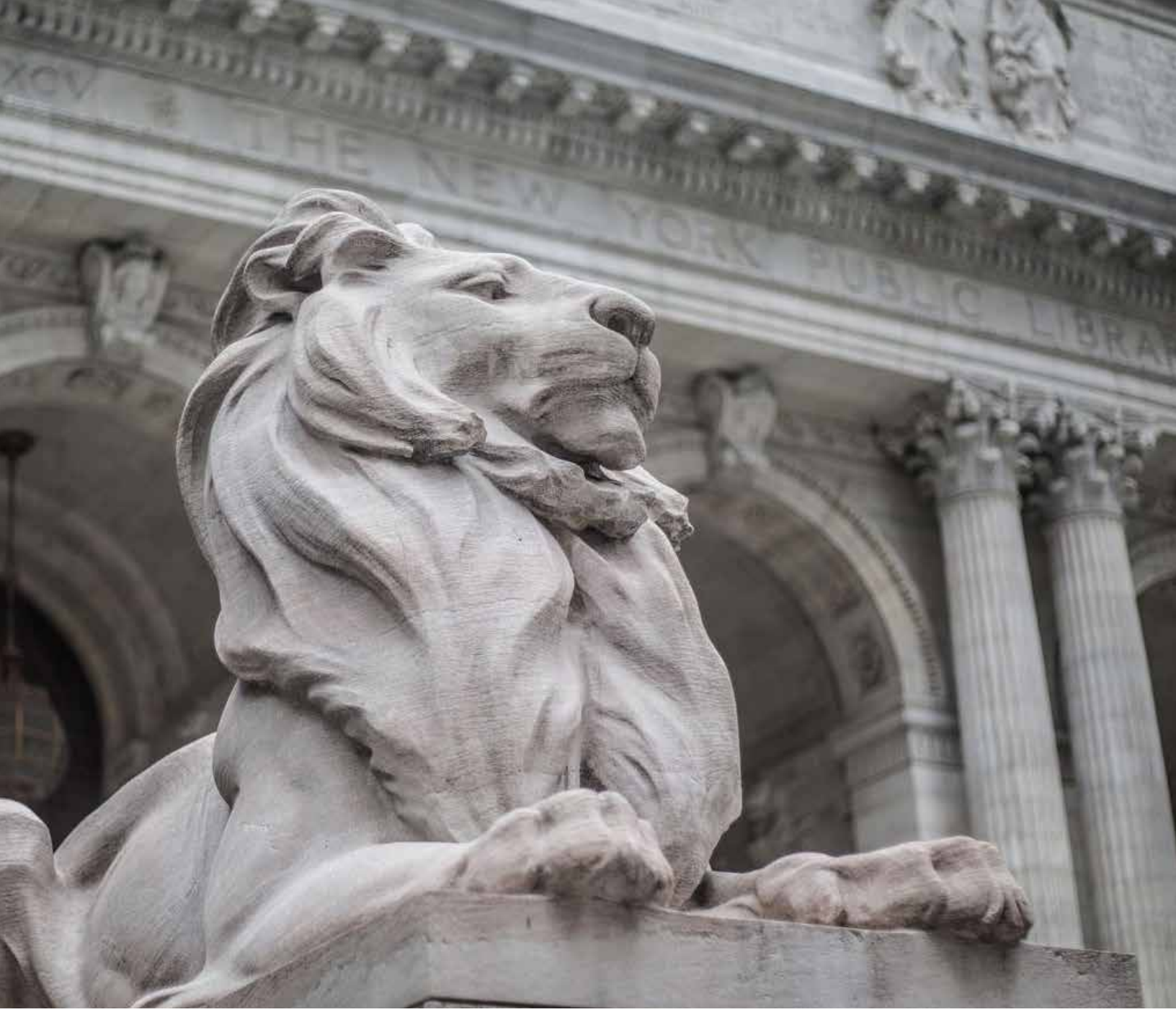


District Council 37
New York Public Library

Health & Security Plan Trust
Benefit Booklet

Covering Active Members and Retirees of The New York Public Library

District Council 37-New York Public Library Health & Security Plan Trust

The benefits described in this booklet are available through the DC 37-New York Public Library Health & Security Plan Trust (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, the benefit allowances, and the 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

Please note: This summary plan description provides benefit information as of the below revision date. For the most current benefits information and guidelines, you are advised to use the website www.dc37.net or contact the Plan's Inquiry Unit at 212.815.1234

District Council 37-New York Public Library Health & Security Plan Trust
H&S Plan Office
55 Water Street, 22nd Floor
New York, NY 10041
212.815.1234

Revised: July 2022

TABLE OF CONTENTS

MESSAGE FROM THE TRUSTEES 2

PART I. ELIGIBLITY FOR BENEFITS 5
- Who Is Eligible For These Benefits? 6
- Enrollment and Change of Status 7
- Coordination of Benefits 9
- Benefits Outline 11

PART II: HEALTH & SECURITY BENEFITS 13
- Introduction 14
- Dental Benefit 14
- Vision Care Benefit 20
- Prescription Drug Benefit 22
- Disability Income Benefit 27
- Second Surgical Consultation 28
- Death Benefit 29
- Extended Death Benefit 30
- Expanded Death Benefit 30
- Enhanced Expanded Death Benefit 30
- Accidental Death & Dismemberment (AD&D) & Loss of Sight Benefit 31
- Audiology Benefit 31
- Personal Service Unit 32
- Legal Services Benefit (Mels) 34
- Health and Pension Services 39
- Survivor Benefit 39
- Annual Medicare Part B Reimbursement Decision 40
- Summary: How To Obtain Benefits 40

PART III: EDUCATION FUND BENEFITS 43
- Education Fund Counseling Service 45
- Bernie Rifkin Solidarity Library 45
- DC 37 CUNY School of Urban & Labor Studies Certificate Program 45
- Career Development 46
- Tuition Reimbursement 46

PART IV: GENERAL BENEFITS INFORMATION 47
- Initial Claims Review Process And Time Frames 48
- Appeals Process 51
- General Information With Respect To Plan Administration 55
- Interpretation 55
- Administration 56
- Plan Year 56
- Employer Contributions 57
- Refund Due Status 57

PART V: ERISA AND OTHER LAWS 59
- Your Rights Under The Employee Retirement Income Security Act of 1974 (ERISA) 60
- Continuation Coverage (Cobra) 62
- Privacy of Protected Health Information 66
- District Council 37 / New York Public Library Health & Security Plan Trust Notice of Privacy Practices 72
- Overview 73
- A Closer Look 74
- Our Uses and Disclosures: How We Typically Use or Share Your Health Information 75
- Changes to the Terms of This Notice 77
- Other Laws And Regulations 77

MESSAGE FROM THE TRUSTEES

Dear Member:

We are pleased to present you with this booklet, the Summary Plan Description, which summarizes the benefits to which members ("participants") of the District Council 37/New York Public Library Health & Security Plan Trust (the "Plan") are entitled. This booklet explains how to determine whether you are eligible for benefits and how to submit claims in order to receive those 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 Plan. 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, agreements with providers of benefits under the Plan's trust agreement, or collective bargaining agreements that established the Plan. Your rights can be determined only by referring to the full text of these official documents, which are available for your inspection at the Helth & Security Plan Office. Please note 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.

The Summary Plan Description describes three separate benefits available under the Plan: Health & Security Plan benefits, Municipal Employees Legal Services ("MELS") benefits, and Education Fund benefits. Please note that, except where otherwise stated, the terms in this Summary Plan Description apply to all three benefits.

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 48.

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 77 for more information concerning this authority.

The Trustees have contracted with the District Council 37 Benefits Fund Trust for the provision of benefits to Participants of the Plan and for administrative and other services. As a result of this arrangement, we are able to make available to you the Vision Centers and other special services that the District Council 37 Benefits Fund Trust has developed throughout the years.

We hope that you will review this booklet carefully and share it with 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 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:

District Council 37 Health & Security Plan
Inquiry Unit
55 Water St., 22nd Floor
New York, NY 10041
212.815.1234

www.DC 37.net

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

In addition to providing a plan of benefits that is responsive to your needs, the Trustees continually evaluate and explore new ways of providing benefits and services. Our goal is to ensure 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 assists you in understanding these benefits and that with your assistance as "an informed consumer," the excellent package of benefits offered will be viable into the future.

Sincerely,

The Trustees

Dated: Aug. 2022

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, such as 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, such as the elimination of lifetime limits on benefits and extension of coverage of dependents to age 26.

Questions regarding which protections do and 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, 55 Water St., 22nd Floor, New York, NY 10041.

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**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PART I.

ELIGIBILITY FOR BENEFITS

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."[1]

MEMBERS AND RETIREES

You are eligible for benefits as described in this booklet if you are a regular full-time or part-time active salaried staff member[2] of The New York Public Library ("NYPL" or the "Library") and work in a job title that is covered by the collective bargaining agreement between The New York Public Library and District Council 37, or you are an eligible retiree.[3]

Employees working in a covered job title become eligible for these benefits as of the first day of employment. Retirees become eligible on the effective date of retirement.

ELIGIBLE DEPENDENTS

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

A member's/retiree's "spouse/domestic partner" is an individual who is the member's/retiree's legal spouse/domestic partner, or who is the member's/retiree's 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 26, regardless of whether he/she lives at home, is in school, is employed, is covered by other insurance, or is married or unmarried.

"Eligible Dependent Children" include:

- The member's/retiree's biological child;
- The member's/retiree's legally adopted child, including children placed in the home for the purposes of adoption;
- The member's/retiree's stepchild;

---

1 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.

2 You are a full-time active salaried staff member of The Library if your salary was figured - on a yearly basis rather than on an hourly, daily, or per-session basis and you are regularly scheduled to work 35 hours or more each week as determined by The Library, in its sole and absolute discretion. You are a Part-time active salaried staff member of The Library if your salary is figured - on a yearly basis rather than an hourly, daily, or per-session basis and you are regularly scheduled to work 17 1/2 hours each week as determined by The Library, in its sole and absolute discretion.

3 You are a retiree if at the time of separation from NYPL you had 10 years or more of full-time active, salaried service at the Library in a covered job title; were Age 55 or older; and immediately submitted your pension application, to the New York State Retirement System. If an application for disability retirement is filed by the staff member while active or on approved leave at NYPL, the retirement age condition will be removed, provided that (1) the staff member notifies NYPL within 30 days of filing for disability retirement from New York State, (2) the staff member notifies NYPL within 30 days of receiving notice of approval for disability retirement from New York State, and (3) disability retirement is approved within one year of filing.

- The child of member's/retiree's domestic partner;
- Children under a court-appointed guardianship who are the member's/retiree's legal dependents.

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 QMCSO 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's/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/retiree **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.

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.

If the member/retiree or dependents 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, 55 Water St., 22nd Floor, New York, NY, 10041, 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's/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:

- Copy of the child's birth certificate;
- 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.

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.DC 37.net** or call the H&S Plan Office at 212.815.1234.

LOSS OF ELIGIBILITY

A Participant's eligibility for all benefits stops when the covered member/retiree is no longer on the payroll (except when member is on an approved unpaid FMLA leave), no longer 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 staff member or retiree. However,

- If the Participant is in the middle of getting certain covered treatments done on their teeth, they have 60 days after becoming ineligible for benefits to complete certain covered treatments in progress.
- If the Participant becomes ineligible while Municipal Employees Legal Service ("MELS") is representing them in a court case or hearing, representation will continue for another 30 days to give the Participant time to find someone else to represent them.

If the member goes off payroll because of a disability[4], he/she and any eligible dependents continue to be eligible for up to six months while the member is collecting disability benefits or Workers' Compensation payments through his/her employer. Please see page 27 for details.

- In the event of the member's/retiree's death, the covered spouse/domestic partner continues to be eligible for benefits for 12 months and may elect COBRA for an additional 24 months, if they were otherwise eligible to receive benefits. See page 39 for more information on Survivor Benefits.
- In the event of loss of eligibility, the Participant and eligible dependents also may have the right to continue medical coverage on a self-pay basis under COBRA. See page 62 for a detailed description.
- If, after becoming eligible, the member is laid off or otherwise terminated and is rehired within 12 months in a covered job title, eligibility resumes as soon as the 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 that might cause the

[4] You are considered to be disabled if a medical examiner approved by the Plan's Board of Trustees certifies that your mental or physical disability prevents you from performing any occupation for wage or profit. The cause of your disability does not have to be related to your occupation.

Trustees to take such action would be a cessation or reduction in the amount of contributions being received by the Plan from the City of New York or contributing employers on behalf of the retirees.

MISCONDUCT AND OTHER EVENTS

There are some acts of misconduct that 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 PLAN UPON LOSS OF DEPENDENT ELIGIBILITY

A member/retiree is responsible for notifying the Plan of any change of status that results in a covered dependent losing eligibility as such under the Plan. This includes, but is not limited to, 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. Supporting documents are not necessary.

NOTE: A member will be responsible for reimbursing the Plan for the cost of any benefits 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. 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 rescind 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.

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 New York Public Library Health & Security Plan.
2. A member's spouse/domestic partner/eligible dependent will be primarily covered for benefits under the spouse's/domestic partner's/eligible dependent's separate plan(s).
3. Unless there is a court decree stating otherwise, when a member's dependent child is covered by more than one Plan, the dependent child will be primarily covered for benefits under the Plan that covers the parent whose birthday occurs first in the year. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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 that covers the parent whose birthday occurs first in the year. Each member will only be covered under his/her plan.
5. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering the same person as a retired or laid-off employee is the Secondary Plan. Except pursuant to #3 above, the same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law, is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree, or covering the person as a dependent of an employee, member, subscriber, or retiree, is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan.
7. The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan.
8. If the preceding rules do not determine the order of benefits, the maximum coverage shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the Primary 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 a member or 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, Home Owner's Liability Insurance, etc., then that insurance coverage shall be Primary and the Plan will 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:

HEALTH & SECURITY BENEFITS ("H&S BENEFITS")

1. **H&S Benefits available to members, retirees, and eligible dependents:**
   - Second Surgical Consultation
   - Dental Benefit
   - Prescription Drug Benefit
   - Vision Care Benefit, including Supplemental Optical Benefit
   - Health & Pension Counseling
   - Personal Service Unit
   - Survivor Benefit
   - Legal Benefits: Available to you (the member or retiree) and your eligible dependents, except for the limitations described on pages 37-38.

   NOTE: The special tax treatment of employer-funded legal service plans ended on June 30, 1992, with the expiration of Section 120 of the Internal Revenue Code. Legal Services benefits are considered as gross income to each covered member and the value of the MELS benefit will be added to your income and reflected on your W2. Because MELS covers only members or retirees living in New York State within 50 miles of the H&S Plan Office, the MELS eligibility criteria have been amended so that those persons who are not eligible for the benefit will not be taxed.

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

   New York City

   Brooklyn – 112

   Bronx – 104

   Queens – 110, 111, 113, 114

   Manhattan – 100, 101, 102

   Staten Island – 103

   New York State

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

   Suffolk County – 117, except 11719, 11764, 11778, 11786, 11789, 11792

   Westchester County – 105, 106, 107, 108

   Rockland County – 109

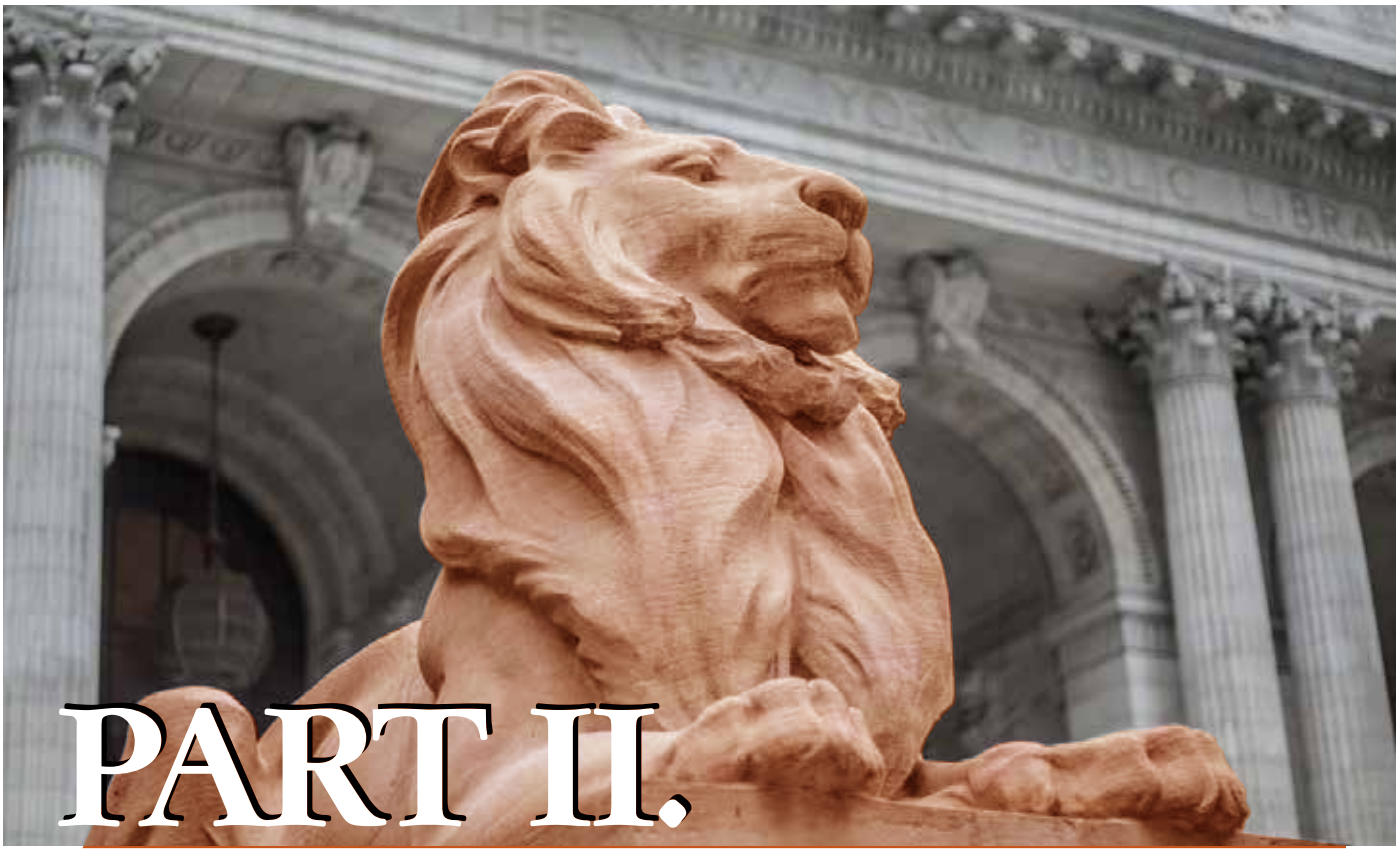
2. **Benefits available to members or retirees ONLY:**
   - Death Benefit
   - Accidental Death and Dismemberment Benefit (retirees not eligible)
   - Weekly Disability Income Benefit (retirees not eligible)
   - Audiology

3. **Benefits available to retirees only:**
   - Medicare Part B Reimbursement as determined annually by the Trustees

EDUCATION BENEFITS

Education benefits are available to members **ONLY**

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. However, you may be entitled to a temporary extension of health benefits under limited circumstances. See section regarding COBRA benefits on page 62 of this booklet.



PART II.

INTRODUCTION

PART II.

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 the 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. Similarly, our Second Surgical Opinion Program was implemented to guard against unnecessary surgery.

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

DENTAL BENEFIT

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

There are **three ways** of using the dental benefit:

1. The member and/or dependent(s) may use any dentist from the Plan's list of Participating Dentists in the participant's Delta Dental network. A Delta Dental participating dentist in the member's Delta Dental network accepts the Delta Dental's fee schedule amount as full payment for covered services. You will be responsible for any cost incurred if you obtain treatment not covered or the cost is above the annual dollar limit allowed. Contact Delta Dental's Customer Service department for DC 37 members at 1.888.523.DC37 (3237) or visit **www.DC37.net** to find a participating dentist in your Delta Dental network.
2. The member and/or dependent(s) may use any licensed dentist who provides these services. If you use a dentist in Delta Dental but not in your Delta Dental network, these dentists will file all claims for you and Delta will reimburse them directly even though they are considered a non-participating dentist in your plan. These dentists are required not to bill you more than their Delta Dental contract permits and you will be responsible for the difference. If you use a dentist that does not participate in any Delta Dental network, then you will be reimbursed by Delta Dental based on its plan's out-of-network allowed fee schedule amount for covered services. You and your dependent(s) will be responsible for any difference between the Plan's out-of-network fee schedule and the dentist's actual charges. Plan rules regarding restrictions, limitations, and annual dollar limit will also apply.

3. The member and/or dependent(s) also may obtain treatment at the DC 37 Dental Center, 115 Chambers St., New York, NY 10007. The same Plan rules regarding restrictions, limitations, and/or annual dollar limit also apply. Individuals who obtain treatment at the Center will be required to comply with policies and regulations established by the Center for its patients. See section on Dental Center Policies page 19.

A **maximum of $1,700** will be paid as benefits for each covered person in a calendar year. Benefits are paid after a claim for completed services is submitted to Delta Dental by the participating Delta Dental provider or by the member when using a non-participating dentist and processed based on Plan rules and guidelines. If you use the DC 37 Dental Centers, the scheduled value of the services provided will be applied toward the $1,700 yearly maximum.

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[4] already begun for up to 60 days after termination or retirement. This is also true for the member's eligible dependents.

Information on how to obtain benefits is on pages 62-66.

PREDETERMINATION REQUESTS

Determine costs ahead of time for all major services, including root canals, crowns, bridges, and dentures by asking your Delta Dental participating dentist to submit a treatment plan to Delta Dental for predetermination of benefits before any treatment is provided. Delta Dental will verify your specific plan coverage, the cost of treatment, and provide an estimate of your costs, if any, and what Delta Dental will pay. **Predeterminations are required for these major services** and your Delta Dental network dentist will submit this predetermination on your behalf so you can make an informed decision about the cost of your treatment, if any.

If using a non-participating dentist, you may use the standard ADA (American Dental Association) dental claim forms available on the DC 37 website at **www.DC37.net** or through Delta Dental Customer Service at 1.888.523.DC37 (3237) or your dentist may submit a universal ADA claim form. Your dentist will describe the proposed work and may attach x-rays to show the work, if necessary. You and your dentist should complete the form and send it to the DC 37 dedicated Delta Dental Customer Service office. Delta Dental reviews the Predetermination request, then notifies you and your dentist if the intended work is covered and to what extent.

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 60-62.

[4] **Only orthodontics, prosthetics or root canal therapy.**

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: Twice in a calendar year, you and your eligible dependents can have your teeth examined by a licensed dentist to check for cavities and other dental or oral problems. You can also have your teeth cleaned twice in a calendar year.

Diagnostic X-Rays: You can have your whole mouth x-rayed once every three years. This does not apply to x-rays necessary to diagnose a specific disease or injury, or to determine progress in its treatment. Benefits will be available for any post-operative x-rays, except in root canal therapy, whenever it is requested by the Plan to help in an evaluation.

Fluoride Treatments: Two per calendar year for eligible dependent children under 19 years of age.

Sealants: For children up to 14 years of age and provided once every three years.

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 to replace a tooth that was extracted while the participant was a covered individual. Bridgework, dentures, and crowns will not be replaced before a five-year period has elapsed from the original date of placement. The five-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-year period, the Plan will only pay for the replacement of the tooth providing it can be added to the existing appliance. (**NOTE:** An abutment tooth is the tooth supporting the fixed or partial denture).

Root Canal Therapy: Payment is once in a lifetime per tooth.

Periodontia: Gum treatments and necessary periodontal care.

Orthodontics: The Plan will pay up to the lifetime maximum of $1,840 for this very important aid to dental health. The benefit is payable once per lifetime per eligible, full-time active employee and Part A Dependent(s). The Plan pays up to 50% of the cost of the care, or the lifetime maximum, whichever is less, for diagnosis and the placement of the orthodontic appliance. The remaining 50% of the cost of the care or the lifetime maximum, whichever is less, will be paid upon the start of the second year of the treatment plan.

DENTAL BENEFITS FOR PART-TIME EMPLOYEES

The dental benefits cover 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 Dental Benefit will reimburse at 75%, on a procedure basis, based on the DC 37 Dental Fee Schedule. Participants will be responsible for the balance of the 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
TOTAL	$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' total responsibility would be $28.75+$80= $108.75.

DENTAL BENEFITS FOR RETIREES

The Dental Benefit, as it pertains to retirees of the New York Public Library, is currently identical to the benefit for members who are full-time active employees, with the exception of the **orthodontia benefit, which is available only to eligible dependent children.** The retiree and spouse/domestic partner are not covered for orthodontia.

In all circumstances, Plan rules regarding restrictions, limitations, and applicable annual dollar limit will apply. The Plan's current dental fee schedule is available by calling DC 37 Customer Service at Delta Dental at 1.888.523.DC37 (3237).

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 two examinations and cleanings per Participant in a calendar year.
3. The Plan does not pay an additional fee for the completion of dental forms.
4. Benefits are not payable for a prophylaxis rendered the same day as a periodontal treatment.
5. Benefits for fluoride are not payable for persons over 18 years of age.
6. Fluoride treatments for persons under 19 years of age are not payable more than twice in a calendar year.
7. Occlusal adjustments are limited to one full-mouth adjustment every five years.
8. No additional allowance will be provided to connect or disconnect units involved in fixed bridgework.
9. Benefits are not payable for temporary crowns unless necessitated by an accidental injury to natural teeth.
10. A temporary restoration (except when necessitated by accidental injury) is considered part of, and is included in, the allowance for the final restoration.
11. No additional benefits will be provided for post-operative treatment.
12. Benefits are not payable beyond a maximum of $1,700 per covered individual per calendar year.
13. Benefits are not payable for the following: (a) an appliance, or modification of an appliance, for which an impression was made before the person became a Participant; (b) a crown, bridge, or gold restoration for which a tooth was prepared before the person became a Participant; or (c) root canal therapy for which the pulp chamber was opened before the person became a Participant.
14. 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 that is extracted while the person is such a Participant and was not an abutment to a partial denture or fixed bridge installed within the immediately preceding five years.
15. 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 that was inserted during the immediately preceding five years. The five-year period shall always commence on the date the device(s), paid for by the Plan, were inserted.
16. 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.
17. Adjustments to dentures and space maintainers are considered part of the allowance if made within six months of installation. The relining of an immediate denture will be considered after six months from the insertion date. An office reline will be limited to once every 12 months. A laboratory reline will be limited to once every 24 months.
18. 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 fee schedule in connection with the dental care of a specific covered condition; **OR**

- 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 fee schedule will be considered to have been incurred in lieu of the charge actually incurred.

19. Expenses incurred after the termination of a person's coverage are not reimbursable except as applicable under the Extension of Benefits Provision as described in the section "Who is Eligible for these Benefits" on page 63.

SERVICES/FEES EXCLUDED FROM COVERAGE

1. Charges in excess of the scheduled fee shown in the Plan's benefit schedule.
2. Charges for procedures rendered before a person became eligible for benefits.
3. A service not reasonably necessary, or not customarily performed, for the maintenance of the patient's health.
4. A service furnished for cosmetic purposes, unless necessitated as a result of an accidental injury sustained while the person was a covered individual.
5. Facing on crowns, or pontics, that are posterior to the first molar are considered cosmetic and are excluded in accordance with exclusion 23 above.
6. Any employment-related disease or injury to the teeth covered by any Workers' Compensation law, occupational disease law, or similar legislation.
7. A service or supply furnished by or for the U.S. Government, furnished by or for any other government unless payment is legally required, or to the extent any benefit is provided by any law or government program under which the person is or could be covered.
8. Charges covered by another group dental insurance plan. See section regarding "Coordination of Benefits" on page 9 for specifics.
9. Replacement of lost or stolen appliances.
10. Any dental service 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.
11. Services covered by any other medical or surgical benefit or insurance program.
12. Charges for oral hygiene instruction, dietary planning, etc.
13. Dental supplies, including, but not limited to, toothbrushes, toothpaste, mouthwash, water-piks.
14. Payment for periodontal surgery is restricted to once every five years. Each quadrant will be considered individually.

NOTE: The DC 37 Dental Center, 115 Chambers St., New York, NY 10007, is available for use by Plan Participants. They can be reached at 212.766.4440.

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

VISION CARE BENEFIT

STANDARD BENEFIT

Once every two 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, 2014, he/she will be reimbursed $15 for the Optical Expense claim. If the Participant files a claim for reimbursement for an eye examination, single vision lenses, and frames he/she will be reimbursed $20. In both examples, the Participant will once again become eligible for Optical Benefits on or after April 1, 2016 (after two years have elapsed).

You have the right to opt out of the Plan's Vision Care Benefit. Please call the Plan at 212.815.1234 for more information.

There are two ways of using your Vision Care Benefit: Optical Voucher or Direct Reimbursement.

1. **Using a Voucher:** Call or write to the H&S Plan Office and request a Voucher, which is accepted by the participating optometrist or optician as full payment for the examination and any necessary eyeglasses, as listed in the schedule on the following page. **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 must use the Voucher within 90 days of the date of issuance. If the Voucher is lost, destroyed, or stolen, you must submit contact the Plan in writing. If an optical Voucher expires, you may contact the Plan's Office at 212.815.1234 to request a new Optical Voucher. A list of participating optical providers is available at the H&S Plan Office and at www.dc37.net/benefits/health/optical. **It is best to always verify with the Provider that he/she is a participating provider prior to scheduling an appointment and receiving services.**
2. **Using Direct Reimbursement:** Plan participants must fill out the Optical Benefit Reimbursement Form that is obtainable from the H&S Plan Office or online at www.dc37.net/benefits/health/optical 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.[5]

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[6]	**$45**

NOTE: Cataract contact lenses can only be obtained through the direct reimbursement method.

REMINDER

In order to maximize your Vision Care Benefit, you must obtain and file for all three services (eye examination, lenses, and frames) simultaneously on the same claim form whether using a Voucher or Direct Reimbursement. 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, meaning that if you receive an examination only and do not obtain lenses and frames, you cannot use any part of the Standard Benefit again for two years. The two-year period is measured from the date of the examinatio**n if only an exam was obtained, or the date of payment if lenses and frames were also obtained.**

[5] **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.**

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

PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit pays the cost, minus applicable co-pay and ancillary charges, of U.S. Food and Drug Administration ("FDA") approved prescription drugs that are on the H&S Plan's formulary and that are prescribed for an FDA approved indication.[7]

GENERIC-BASED PRESCRIPTION DRUG BENEFIT ACTIVE MEMBERS & NON-MEDICARE ELIGIBLE RETIREES (OPTUM RX)

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 is available to covered active members, non-Medicare eligible retirees, and eligible dependents. The Prescription Drug Benefit consists of a three-tier, co-payment program in effect as of Jan. 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
Prefered Brand	$20	$60	$40
Non-Prefered Brand	$45.50	$136.50	$91

NOTE: Many generic statin drugs are available to participants for $0 co-pay for 30- or 90-day supplies.

If you choose to obtain a brand name drug that has a generic equivalent, 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 covers just two classes of medication: Injectables and Chemotherapy. Psychotropic and Asthma medication coverage reverted to the Plan's responsibility and are subject to Plan rules and co-payments.

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[7] **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.**

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

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. You should take the card and your prescription, which must be written on your physician's prescription pad, to a participating pharmacy. When obtaining medication from your neighborhood participating pharmacy, you can get 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 co-payments. Certain specialty drugs that require special handling are filled through a specialty mail order pharmacy. In the event 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 Inquiry Unit at 212.815.1234.

HOW TO USE THE 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/benefits/health/prescription**, and send the form along with the prescription receipt to the Plan's Prescription Drug Benefit Administrator at DC 37 Health & Security Plan, 55 Water Street, 22nd Floor, Attn: Drug Unit, New York, NY 10041, 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, 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 & THE DC 37 NEW YORK PUBLIC LIBRARY 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 HIP/VIP and other Medicare Advantage Plans ("MAPs"), are enrolled automatically in the DC 37 Medicare Part D Retiree Plan administered by Aetna SilverScript. 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.

One hundred and twenty (120) days before a retiree or Medicare-eligible dependent reaches the age of 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 a health insurance claim number and a mailing address if there is only a post office box on file. It also provides the option of opting out of the DC 37/Medicare Part D Plan to be in a private plan of his/her own choosing. By law, a retiree cannot be in two Medicare Advantage Plans at the same time. Retirees who are members of one Medicare Plan will be disenrolled from all coverage, including medical coverage provided by that plan if they enroll in a second Medicare Plan.

Once the H&S Plan receives the retiree's Medicare information, it is forwarded to Aetna SilverScript (the Sponsor) so that the retiree can be enrolled. Aetna SilverScript sends a welcome package to the retiree that explains the benefit. Once the retiree is enrolled, he/she is sent a prescription drug card by Aetna SilverScript. For further information on this benefit, please call the Aetna SilverScript's Customer Service toll-free number at 1.855.858.1939.

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

THE PREFERRED PRODUCTS LIST

The Plan has instituted a Preferred Products List identifying 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 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. Remember, **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 co-payments as opposed to a 90-day supply at a Retail Rx pharmacy for three co-payments. Please allow 14 days for delivery from the date you mail in the original prescription. Be sure to enclose a check or provide a credit card number to cover the cost and/or the co-payments 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.DC 37.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.

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[8] **See Important Note regarding diabetes coverage on p.25**

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, eczema, attention deficit hyperactivity disorder, asthma and allergy, depression, rheumatoid arthritis, diabetes,[8] pain and arthritis, and ulcer and gastro-esophageal reflux disease.

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, 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/benefits/health/prescription**, 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 Appeals Committee; if denied you may appeal to the full Board of Trustees[9]).

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 and the medication will not be covered by the Plan.

NOTE: If you were prescribed a Step Two medication in the past and have not filled a prescription for it in 120 days or longer, you will not be able to restart 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.

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[9] **See page 51 for more information on appeals.**

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 Medicare eligible dependents enrolled in the DC 37 Medicare Part D Retiree Plan, all prescription drugs are provided through Aetna SilverScript.

EXCLUSIONS/LIMITATIONS

The Prescription Drug Benefit will not cover the cost of:

1. 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.
2. Drugs prescribed for any condition covered by Workers' Compensation, No Fault Automobile Insurance, or in any situation where third-party medical insurance is available.
3. Chemotherapy obtained by a non-Medicare-eligible member and/or eligible dependent, administered on an out-patient basis in a hospital or in a doctor's office, as these service are covered under the NYC PICA program.
4. Drugs including vitamins, foods, and dietary supplements that may be purchased with or without a prescription.
5. Drugs supplied by a treating physician.
6. Investigational or experimental drugs.
7. Over-the-counter drugs purchased with or without a prescription.
8. Prescription medications that have over-the-counter counterparts.
9. Appliances and all companion implements (devices), including syringes and needles for the administration of prescription drugs.
10. Drugs prescribed for cosmetic purposes.
11. Prescription drugs used for intravenous drug therapy that are infused in the home (and any charge for the administration of home infusion of the drug).
12. Immunization agents and biological sera.
13. Refills of medication covered by the benefit described in this section in excess of 11, 30-day refills in any 12-month period.
14. Refills of maintenance drugs covered by the benefit described in this section in excess of three, 90-day supplies in any 12-month period filled at the Plan's mail order program or a retail 90 pharmacy.

15. Diabetes medication for active members, non-Medicare-eligible retirees, and eligible dependents except as noted on page 25 under Important Notes, #1.
16. Chemotherapy and related medications for members, non-Medicare-eligible retirees, and eligible dependents enrolled in the City of New York's Health Benefits program except as noted on page 26 under Important Notes, #3.
17. Injectable medications for members, non-Medicare eligible retirees, and eligible dependents enrolled in the City of New York's Health Benefits program except as noted page 26 under Important Notes, #2.

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, must be dispensed through our mail service program, 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 Optum Rx. 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, or No Fault Insurance, 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

Employees of the New York Library are covered by New York State Disability Insurance. The Disability Insurance offered by the Plan is secondary and coordinates with the state coverage (i.e., any benefit you receive from the state is paid first). The Plan benefit will only be paid if the 26 weeks of New York State Disability benefits are exhausted and the member remains disabled.

Under the Plan, a covered, full-time member is entitled to receive up to a maximum of $200 per week for the period of the disability, but not longer than 26 weeks.

A covered, part-time member is entitled to receive up to a maximum of $98 per week for the period of the disability, but not longer than 13 weeks.

Disability Benefits are not paid for in the following circumstances:

1. Periods of disability caused by cosmetic surgery.
2. Self-inflicted injuries.
3. War-related disabilities.
4. Injuries received as a result of the commission of a crime.
5. An illness or injury arising out of employment.
6. A disability caused by, or resulting from, a motor vehicle accident where the member is covered under No-Fault Insurance.
7. A disability arising from peace-time military service.
8. A disability associated with an act that the Trustees consider to be a wrongdoing equivalent to the commission of a crime.
9. 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 at 212.815.1250.

No Disability Benefits are paid while the member 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 six months from the time you go off payroll. No Disability Benefits are paid if the member is receiving Social Security Disability payments or Veteran's Administration payments that 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.

We regularly arrange for members to be 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, 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 H&S Plan office at least two weeks before you leave or your claim will be disallowed or payments will be discontinued.

F.I.C.A. (Social Security) tax is not withheld from the weekly Disability Benefit check. However, the disability payments are included in your gross income at the end of the year and included on the NYPL issued W-2. Information on filing Disability claims is on page 52.

SECOND SURGICAL CONSULTATION

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.

All surgeries involve some level of 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 who 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 at 212.815.1350, or through NYC Healthline at 800.521.9574. For information on how to get a Second Surgical Consultation, see page 41.

DEATH BENEFIT

When an active, full-time working member 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 $2,000 will be paid to his/her beneficiary(ies).[10]

A member or retiree has the exclusive right to designate beneficiaries or change any designation of beneficiaries without the consent of those beneficiaries. The designation and/or change of beneficiary must be made upon forms specifically provided by the Plan for that purpose, which can be found at **www.dc37.net/benefits/health/hs_forms**

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 to the parents of the beneficiary or in one lump-sum payment to the legal guardians of such minor.

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

All members are reminded that beneficiary designations are treated as confidential information and will not be disclosed by the Plan unless authorized by the member or retiree, or required by law.

Except where a member retires and becomes eligible for the $2,000 retiree Death Benefit, coverage for the Death Benefit ends 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 months after the payroll date.

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[10] **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. Received the maximum Disability Benefit provided by the Plan;
2. Be under age 55;
3. Remained disabled until his/her death;
4. Uninsurable and unemployable;
5. Not receiving a pension from a current employer; and,
6. 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.

EXPANDED DEATH BENEFIT

The expanded death benefit is available to a member **age 55 or older** 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. Received the maximum disability benefit provided by the Plan;
2. Be 55 or older;
3. Remains disabled until his/her death;
4. Uninsurable and unemployable;
5. Not receiving a pension from a current Employer; and,
6. 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 years after the member first met all of the above conditions, or the benefit is discontinued.

ENHANCED EXPANDED DEATH BENEFIT

If a member with 10 years of continuous employment qualifies for an expanded death benefit and is **over 55 and under 62**, he/she 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 by the sole and absolute discretion of the Trustees.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) & LOSS OF SIGHT BENEFITS

Available to active members only.

If an active 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 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, he/she will receive a benefit of $5,000 for each lost limb or eye. 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 eyesight 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 that is wholly or partly caused by or contributed to, directly or indirectly by:

1. Disease or bodily or mental illness or medical or surgical treatment thereof.
2. Ptomaines, bacterial infections, except pyogenic infections, occurring with and/or through an accidental wound.
3. Suicide or intentionally self-inflicted injury, while sane or insane.
4. Participation in, or as a consequence of having participated in, an act that 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 the Trustees consider to be a wrong-doing that is equivalent to the commission of a crime.
5. War or any act of war, whether declared or undeclared or peacetime military service.
6. 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.
7. 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 Benefits, see page 41.

AUDIOLOGY BENEFIT

The Audiology Benefit is provided in response to the many members who suffer hearing loss problems and don't have ready access to affordable, quality care.

This benefit is available to members and retirees **only** (not to eligible dependents) and only at the DC 37 Audiology Center, 55 Water St., New York, NY 10041, phone: 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, 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 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 who have coverage through an HMO must follow the procedures established by their carrier for seeing a specialist.

After seeing the ENT doctor and obtaining medical clearance for hearing aids, the member or retiree will be seen for a hearing aid evaluation at the DC 37 Audiology Center located at 55 Water St., New York, NY 10041. At that time, the Audiologist will review the types of hearing aids available. If the member or 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, which must be paid by check or money order at the dispensing appointment.

The member or retiree will return for a hearing aid dispensing. The hearing aids will be programmed and dispensed with a 45-day trial period. The member or 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. It is located at the DC 37 Health Center, 55 Water St., 22nd Floor, New York, NY 10041. Call 212.791.2126 to make an appointment.

SERVICES & COSTS NOT PROVIDED BY THE AUDIOLOGY BENEFIT

1. Subsequent battery replacements (initial batteries come with the hearing aids).
2. Hearing Aid repairs, except those under the manufacturer's warranty, are not covered.
3. Costs associated with rehabilitation therapy needed to acclimate the user to the hearing aid
4. Claims for hearing aids obtained outside of the Audiology Center.
5. Assistive listening devices.

NOTE: If your basic health insurance coverage provides reimbursement for an audiology benefit, you will be required to sign an authorization form allowing Hear & See Right, Inc. to file a claim with your insurance carrier.

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. 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 requiring assistance.

To help you deal with crises or problems like these, the Plan has set up a special unit called the Personal Service Unit (PSU). The unit's counselors are professionally trained New York State Licensed Social Workers

who may be able to help you directly with short-term counseling, provide information about private or public social services to which you may be entitled, or refer you to an proper community agency to help resolve your difficulties. **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

SERVICES OFFERED

1. **Referrals:** 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:** PSU staff will provide a list of resources available in the community for members and their dependents who need information only.
3. **Individual Counseling:** 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:** PSU staff will provide small, informal group counseling for Participants with similar needs. PSU develops group programs in response to needs. Refer to the *PEP Talk* newspaper for announcements of pending groups or call PSU for information.
5. **Workshops and Conferences:** PSU staff periodically provides participatory workshops and conferences such as Pre-Retirement Planning workshops and Stress Management workshops.
6. **Outreach Program:** PSU staff, together with a volunteer program of retirees, will assist:

   - Pre-retirees to prepare for retirement.
   - Retirees dealing 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, from 9 a.m.-1 p.m. If they are busy providing services to other members, their telephones will be answered by an answering machine. The member may have to call a number of times before getting a social worker due to the large volume of calls coming into the unit. You may also contact PSU in person at their office, Monday-Friday from 9 a.m.-Noon.

WHAT TO EXPECT

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

LEGAL SERVICES BENEFIT (MELS)

The Legal Services Benefit is a program of personal legal services for active members, retirees, and eligible dependents. Because legal problems are often closely linked to personal and financial concerns, the staff also includes social workers to help clients with such concerns.

The District Council 37 Health & Security Plan's Municipal Employees Legal Services (MELS) maintains a team of dedicated lawyers, social workers, and support staff to advise, counsel, and represent members and eligible dependents on certain covered matters (described below). The lawyers and social workers are licensed to practice law in New York. They work full-time for MELS,and are not permitted to have an outside law practice.

COST OF SERVICES

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

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

COVERED MATTERS

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

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

1. **Wills:** A Plan lawyer will prepare wills, health care proxies, living wills, and durable powers of attorney for you and your spouse/domestic partner.
2. **Debt:** If you have debt problems resulting from loans, including a mortgage on your house, installment contracts, collection actions against you by creditors, or any other financial obligations you are unable to meet, the legal staff will give you advice and counsel, and will represent you if you are sued for more than $500 and have a legal defense. If bankruptcy is advisable in your situation, the Plan will provide counseling and represent you in a bankruptcy proceeding.
3. **Purchase of Goods and Services:** You may consult a Plan lawyer for advice and counsel on any dispute you have with a seller over merchandise or services you have bought. If you have a claim to bring, the Plan will represent you if the amount in dispute exceeds the monetary jurisdiction of Small Claims Court. If the amount is within Small Claims jurisdiction, the Plan will refer you to a Small Claims Court and advise you on how to represent yourself there most effectively.

   If your claim is more than $500 and within Small Claims Court jurisdiction, the Plan will first try to negotiate a settlement for you before referring you to Small Claims Court.
4. **Evictions:** The Plan will represent you in an action your landlord brings against you that might result in eviction from your primary residence.
5. **Divorce, Separation, and Annulment:** You may come to the Plan for consultation and representation in divorce or civil annulment proceedings and for the preparation of separation agreements. The Plan provides services to you in these matters, including representation regarding maintenance, support, custody, visitation rights, and property division.
6. **Document Review:** You can avoid a lot of legal problems by asking for a lawyer's advice before you sign any written agreements, particularly if the sum of money involved is substantial. If such documents concern covered matters, a Plan lawyer will review them and advise you. The Plan will review documents in matters such as consumer purchases, home improvement contracts, loans and leases, purchases of one- or two-family houses, co-op apartments, condominiums, and insurance.
7. **Credit Rating:** The Plan will help you correct inaccurate information on your credit report. If you have been denied a loan or other credit because of your credit rating, the Plan will help you obtain the credit report from a credit reporting agency. If any items are inaccurate, the Plan will seek to have the credit reporting agency correct them.
8. **Public Utilities:** The Plan will help you with billing disputes with electricity, gas, and telephone companies, provided the amount in controversy exceeds $500. If your services have been shut off or if the utility is threatening to shut off services, the Plan will give you legal assistance without regard to the amount in controversy.
9. **Government Agency Entitlements:** The Plan will advise and counsel you on securing your entitlements from government agencies, and will also represent you in hearings before those agencies, in any dispute regarding benefits provided the amount in controversy exceeds $500.
10. **Other Administrative Agency Matters:**
    - Administrative hearings with public housing. The Plan will assist you in determining whether your rent in public housing is correct.
    - Applying for and transferring within public housing, and applying for housing subsidies, if there have been disputes regarding your application for these benefits.

- If you are eligible because of your age or income, the Plan will help you obtain an exemption from a rent increase, ("SCRIE") if you have been denied this benefit.
- Public school suspension matters involving disciplinary charges and in special education placement.
- Correct errors in your birth certificate if you were born in New York State.

11. **Defending Tort Lawsuits:** The benefit for the defense of tort matters is limited to the payment of reasonable attorney fees not to exceed $300. No benefit is provided without prior written approval by the Plan, and unless the amount demanded is in excess of $500. You are not entitled to this benefit if you are entitled to representation under an existing insurance policy or are otherwise required by law to have an insurance policy.
12. **Real Estate Transactions** (not available to members who are part-time employees, or their dependents): The Plan will represent you in the transaction involved in buying or selling a one-family house or co-op apartment or condominium, which is your primary residence. The Plan will also represent you in buying a two-family house that is your primary residence.
13. **Citizenship:** The Plan will help you apply for citizenship if you are a permanent resident of the United States.
14. **The following services are available to full-time, active members and their dependents only; not to part-time members.**
    - **Family Court:** The Plan will advise and represent you in disputes over custody, visitation, and paternity of children, and will provide representation for a parent (or a relative acting in the parent's place) in child neglect, abuse, or foster care cases. Representation of foster parents will be limited to those foster parents having had custody of a child for more than 24 months. The Plan will provide advice only on support matters. The Plan also covers cases involving spousal abuse and other domestic violence, helping to obtain orders of protection and related relief. Representation will not include cases brought in Criminal Courts.
    - **Adoption:** The Plan will represent you in a proceeding for an adoption of a minor child.
    - **Guardianship:** The Plan will represent you in obtaining letters of guardianship over a minor child.
    - **Name Change:** The Plan will represent you in a proceeding to change your name.

SOCIAL WORKERS

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

HOW TO SEE YOUR LAWYER

To make an appointment to see a MELS lawyer, call 212.815.1111. Your call will be answered by a legal assistant. Please be ready to provide your PID or Social Security number. You may also be asked for your present job title and the name of the institution you work for. The Plan needs this information to verify your eligibility.

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

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

IF YOU HAVE A REAL EMERGENCY AND CAN'T WAIT

Be sure to explain your situation when you call for an appointment. If you are eligible and the problem is covered, MELS staff will make every effort to get you an appointment early enough to take care of the emergency.

WHERE YOU WILL BE REPRESENTED

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

SERVICES ARE CONFIDENTIAL

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

LIMITATIONS ON THE BENEFIT

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

1. **Dispute Between Covered Member or Retiree and Eligible Dependent:** Lawyers cannot represent both sides of a dispute because to do so would be a conflict of interest. Accordingly, if a dispute arises between two members of your family who would otherwise both be entitled to representation by the Plan, MELS will represent only the covered member/retiree. For example, if you are the covered member and you came to the Plan for a divorce, MELS would represent you but would not represent your spouse/domestic partner.

1. **Dispute Between Two Covered Members/Retirees:** If the dispute is between two covered members, or between two retirees, or between a covered member and a retiree, the Plan will not represent either party. Instead, the Plan will pay reasonable fees, not to exceed $300, for an outside attorney for each member or retiree entitled to representation. This will also be true if two spouse/domestic partners seeking divorce or separation are each covered as either an active member or a retiree.

2. **Outside Legal Fees** (applicable only in cases of conflict described above): The Plan will not pay more than $450 in one year toward the total cost of outside legal fees for the family of any Participant. You must apply for and receive approval for reimbursement of any outside legal fees prior to incurring said outside legal fee.

3. **Prior Representation:** The Plan will not represent you in a matter in which you have previously received representation from another lawyer.

EXCLUSIONS

Any matters not listed specifically as covered above are excluded. Some examples of the kinds of matters that are excluded are:

1. Criminal matters, including juvenile delinquency.
2. Matters relating to business, commercial, and professional ventures in which you or your family is personally involved.
3. Matters relating to other income-producing ventures, including landlord-tenant disputes where you are the landlord.
4. Matters that would commonly be handled by a private lawyer on a contingent fee (percentage) basis, such as suits for libel, slander, malpractice, personal injury, or property damage;
5. Matters arising out of ownership, control, or use of a vehicle, parking and moving violations.
6. Claims against DC 37 or any of its affiliated organizations, Health & Security Plan officers and staff, the City of New York and related agencies. and the State of New York in their employer capacity and their respective pension funds;
7. Disputes between other employers and their employees, including matters related to such employment, such as pension and benefit entitlements.
8. Immigration matters other than citizenship, tax matters, patent and copyright, probate, and administration of estates.
9. Disputes between landlord and tenant not leading to eviction.
10. Matters in which legal services are available through insurance, or where insurance is mandated by law, or where representation is available to the covered member under other group legal plans.
11. Matters involving union-administered health, education, or other benefit plans, such as DC 37 Med Team/ GHI. However, Blue Cross, Blue Shield, HIP, and GHI matters will be handled where such representation will not involve claims against DC 37 and its related Funds.
12. Representation in the purchase or sale of a multi-family dwelling.
13. Representation in Small Claims Court.

Part-time members, retirees, and eligible dependents are excluded from receiving MELS benefits for:

1. Real estate transactions
2. Family court matters
3. Adoption
4. Guardianship
5. Name Changes

TERMINATION OR SUSPENSION OF LEGAL SERVICE BENEFITS

Except for representation in litigation, which will continue for 30 days after eligibility ceases for the purpose of winding up a case or substituting another attorney, the Plan will terminate your legal service benefits:

1. When you leave the employer's payroll (except for retirement or when on an unpaid FMLA leave);
2. When you are transferred to a job title not covered by the Plan;
3. When you retire without becoming a covered retiree;
4. When a benefit is discontinued by the Plan;
5. When the Plan itself is terminated; or
6. When the Trustees determine in their sole and absolute discretion that you have engaged in conduct that warrants suspension or termination of benefits due to misconduct, such as commission of fraud against the Plan.

HEALTH AND PENSION SERVICES

The Health and Pension Services Unit assists members who have questions about 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

Health and Pension Services provide information about the New York City pension plan (NYCERS). Members of this NYPL Trust are not members of the NYCERS plan, and are instead eligible for membership in the New York State Retirement system (NYSLRS). You can call NYSLRS directly at 1.866.805.0990 for assistance. In addition, members can contact The New York Public Library Human Resources Service Center at 212.621.0500, prompt 4, to make an appointment with someone in the Total Rewards Office for pre-retirement counseling.

SURVIVOR BENEFIT

Upon the death of a covered member/retiree, eligible dependents can continue to utilize the applicable Plan benefits for a period of 12 months from the member/retiree's date of death.

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

The survivor's benefit package will be available for one year from the member's date of death. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides a surviving spouse/domestic partner and eligible dependents with the opportunity to continue these benefits by purchasing them for up to an additional two years.[11]

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 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 form SSA 1099 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/New York Public Library 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 to 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 size of your family, the Plan must be told of the changes.

See page 7 for more information.

When a member completes an enrollment form, a beneficiary is also designated for the Plan's Death Benefit. If a member/retiree experiences status changes as indicated above, or a previously named beneficiary has moved or is deceased, it is recommended that the member/retiree update the Plan's records. Please note that the Plan cannot release the name of your beneficiary to you by phone or in writing. You can call the H&S Plan Office and request a change of beneficiary form, or you can download the form from the website at **www.DC 37.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.

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.

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 212.815.1234. 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, 55 Water St., 22nd Floor, New York, NY 10041.

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[11] **See page 62 for more information about COBRA continuation coverage.**

SECOND SURGICAL CONSULTATION

Call the Plan at 212.815.1351 or call the NYC Health Line at 800.521.9574 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. They must be filed within 30-days after the work is completed. Orthodontic claims may be filed quarterly. Please see dental section for pre-authorization requirements.

PRESCRIPTION DRUG BENEFIT

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

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 30 days after you have paid for your glasses.

DISABILITY INCOME BENEFIT

You must file the completed Disability claim form no later than 30 days after the end of your New York State Disability payments.

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, the benefit will be paid according to the rules and regulations of the Plan. These forms must be returned to the Plan with a certified death certificate within 30 days.

ACCIDENTAL DEATH & DISMEMBERMENT, AND LOSS OF SIGHT BENEFITS

The form must be completed by a doctor and filed within 30 days of a death or loss of sight or limb. Form should be submitted to DC 37 Death Benefit Unit, 55 Water St., 22nd Floor, New York, NY 10041.

AUDIOLOGY BENEFIT

Call 212.791.2126 to make an appointment at the Audiology Center, 55 Water St,, New York, NY 10041.

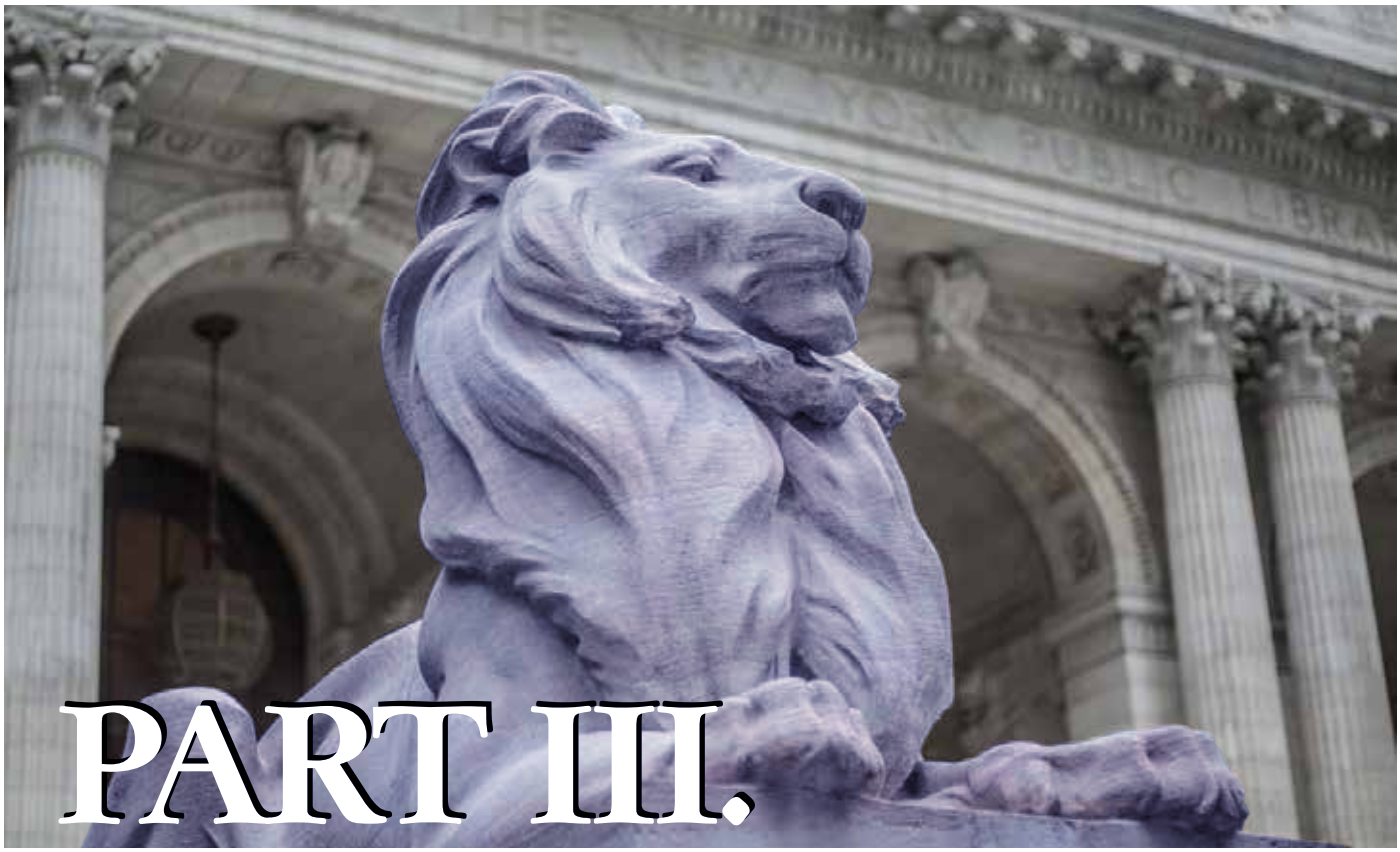
PERSONAL SERVICES UNIT (PSU)

Call PSU at 212.815.1260, Monday-Friday, from 9 a.m.-1 p.m. with questions or to make an appointment.

LEGAL SERVICES (MELS)

To make an appointment to see a MELS lawyer, call 212.815.1111. Your call will be answered by a legal assistant. Please be ready to provide your PID or Social Security number. You may also be asked for your present job title and the name of the institution you work for. If you are calling for an appointment and you are the spouse/domestic partner of an eligible member or retiree, you should be prepared to give this same information about your spouse/domestic partner.

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



PART III.

EDUCATION FUND BENEFITS

PART III.

EDUCATION FUND BENEFITS

Available to active members only.

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

As the educational and career needs of our members continue to evolve, the Fund's program offerings continue to grow as well. The Education Fund offers technology courses, 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 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 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. For a program application, class locations, or program information, members may call the Education Fund at 212.815.1700. To download an application, members may go to **www.DC 37.net** and click on the Education link. Members may also look for new programs and program descriptions in the *PEP Talk* newsletter.

LOCATIONS

While most programs are held at DC 37 headquarters, 55 Water St., New York, NY 10041, there are adult learning centers in designated locations throughout the city. Each adult learning center provides both group and individualized instruction to those members 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.DC 37.net** and click on 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 advancing 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 information to design your educational future. Call 212.815.1700 for an appointment.

BERNIE RIFKIN SOLIDARITY LIBRARY

The Education Fund Library offers a circulating collection of popular materials that can be borrowed for up to 28 days and a basic reference collection. Whether you're interested in popular fiction, current events, history, women's studies, Black or Latinx 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, 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.

All classes are currently being held online. You can access **www.DC 37edfund.org/courses** for more information.

DC 37 CUNY SCHOOL OF URBAN AND LABOR STUDIES CERTIFICATE PROGRAM

District Council 37 Education Fund, in partnership with the CUNY School of Urban and Labor Studies, offers a Certificate in Public Labor Relations. This 16-credit undergraduate certificate program provides a comprehensive overview of labor relations in the public sector.

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

Classes are held on scheduled weekday evenings from 6 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 one-time $70 admission fee and books, are covered for eligible DC 37 members.

The program is held at the CUNY School of Urban and Labor Studies, 25 W. 43rd St., 19th Floor, New York, NY 10036. To learn more about the program, 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 $915 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 also may be reimbursed for on-line 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 $915 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 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 NYPL for the same term may be required.

Tuition reimbursement payments cannot exceed the $915 maximum per calendar year. Members may apply each year.

NOTE: 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.DC 37.net** and click on to the Education Fund link to download an application for tuition reimbursement.

PART IV.

GENERAL BENEFITS INFORMATION

PART IV.

GENERAL BENEFITS INFORMATION

INITIAL CLAIMS AND APPEALS PROCESS & TIME FRAMES

For more information on how to submit claims, see page 51.

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, Dental, and Optical benefits claims must be submitted within 30 days of the date of service.
- Death Benefit claims must be submitted within 30 days of the date of death.
- Claims for Disability Income Benefits must be submitted within 30 days after the event, medical, or accidental, which gives rise to the disability.

A claim for a benefit that is filed later than the above required time for filing may, at the Plan's sole and absolute discretion, be accepted and processed if all of the following conditions are met:

- Claim is received by the Plan 90 days or less after the claim for the particular benefit has accrued as provided herein; and
- Claimant submits a statement explaining the reasons why the claim was filed late and it is determined that the claimant has stated good and reasonable grounds by way of explanation for the late filing.

CLAIMS UNDER THE DENTAL, OPTICAL, AUDIOLOGY, PERSONAL SERVICES UNIT, AND PRESCRIPTION DRUG BENEFITS

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

CLAIMS REQUIRING PRE-CERTIFICATION (DENTAL AND PRESCRIPTION DRUG)

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

CLAIMS INVOLVING URGENT CARE THAT REQUIRE PRE-CERTIFICATION

A "claim involving urgent care" is any claim for care that 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 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 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 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 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 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 also will be provided within three 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, taking into account the medical exigencies. Notification of the Plan's determination must be provided to the claimant within 24 hours after receipt of the claim when the request is made at least 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 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as an additional 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 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 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). The Participant shall be afforded at least 45 days within which to provide specified information (if applicable).

DEATH BENEFIT, ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT, 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 90 days after this Plan receives the claim, this Plan will send the Participant written notice of its decision, unless special circumstances require an extension, in which case the Plan will send the Participant written notice of the decision no later than 180 days after the Plan receives the claim. If an extension is necessary, the Participant will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination.

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: (a) the date on which the Participant respond to the Health and Security Plan's request for additional information, or (b) 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, including a statement of the claimant's right to bring a civil action under section 502(a) following an adverse benefit determination on review;
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.

Claims involving urgent care will have a description of applicable expedited appeal procedures. The information described above may be provided to the claimant orally within the time frame specified herein, provided that a written or electronic notification is furnished to the claimant not later than three days following an oral notification.

APPEALS PROCESS

Some claims may be denied, in whole or in part, because of improper filing, because your benefit claim is not covered, or because of ineligibility for the benefit. If you feel that your claim 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 Appeals Committee of the DC 37/New York Public Library Health & Security Plan, and the second level is to the full Board of Trustees.

FIRST LEVEL: APPEALS COMMITTEE APPEALS

If the Participant is not satisfied with the reason(s) why the claim was initially denied, the Participant should first appeal to the Appeals Committee. The Participant must write to the Appeals Committee of the District Council 37/New York Public Library Health & Security Plan, 55 Water St., 22nd Floor, New York, NY 10041, within 180 days after receiving the Plan's initial adverse benefit determination.

SECOND LEVEL: FULL BOARD OF TRUSTEES APPEALS

If the Participant's appeal to the Appeals Committee is denied and the Participant is not satisfied with the reason(s) for denial, the Participant may appeal to the full Board of Trustees. The Participant must write to the Board of Trustees of the District Council 37/New York Public Library Health & Security Plan, 55 Water St., 22nd Floor, New York, NY 10041, within 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 a 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, Personal Services Care Benefit, or Disability Benefit:

1. The review will not afford deference to the initial adverse benefit determination or 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 or the subordinate of such individual;
2. Insofar as the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, 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, or the subordinate of such individual;
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; and
5. In the case of a claim involving urgent care, for an expedited review process pursuant to which (a) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (b) all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

In regard to all appeals involving the Disability Benefit: (a) before the Plan can issue an adverse benefit determination on review on a disability benefit claim, the Plan Administrator will provide the claimant with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination in connection with the claim; and (b) before the plan can issue an adverse benefit determination on review on a disability benefit claim based on a new or additional rationale, the Plan Administrator will provide the claimant with the rationale.

WHAT MUST BE INCLUDED IN A PARTICIPANT'S APPEAL LETTER

1. Clearly indicate you are appealing the decision;
2. A statement signed by the Participant, if applicable, indicating the assignment of any representative;
3. Type or nature of the claim;
4. Reason it was denied;
5. Reasons why the claimant believes the claim should be accepted; and
6. Any other information that the claimant feels should be considered on the appeal. This appeal must be filed within 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 Benefits Requiring Pre-certifications:** The Participant will be notified of the Appeals Committee's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review.
- **Urgent Care Claims:** The participant will be notified as soon as possible, taking into account the medical urgency involved, but not later than 72 hours after receipt of the request for review.
- **Disability Claims:** The Participant will be notified of the Appeals Committee's decision within a reasonable period of time, but not later than 45 days after receipt of the request for review.
- **All Other Claims:** The Participant will be notified of the Appeals Committee's decision within a reasonable period of time, but not later than 60 days after receipt of the request for review.

Time Frames for Full Board of Trustee Appeals (Except Urgent Care Claims)

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

NOTE: For Urgent Care claims, the Participant will be notified of the full Board's decision as soon as possible, taking into account the medical urgency involved, but not later than 72 hours after receipt of the request for review.

CONTENT OF ADMINISTRATIVE APPEALS DECISIONS

The Plan's written notice of the Appeals Committee's decision will include:

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 statement that the claimant and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way for claimants to find out what may be available is to contact their local U.S. Department of Labor Office and their state insurance regulatory agency.
7. A description of the Plan's appeal procedure and the time limits applicable to such procedures.

CONTENT OF FULL BOARD OF TRUSTEE APPEALS DECISIONS

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

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.

DECISIONS BY THE FULL BOARD OF TRUSTEES 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. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, including the second level appeal to the Board of Trustees. Thereafter, you may file a lawsuit under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"). However, any such lawsuit must be filed within 180 days from the date the adverse benefit determination denying the appeal, is deposited in the mail to the last known address of the Participant, and also within any statute of limitations which may apply.

Effective April 1, 2018, the following applies to claims and appeals for any benefit determination conditioned on a finding of disability by the Plan. These rules do not apply to a determination conditioned on a finding of disability by a party other than the Plan (e.g. the Social Security Administration).

1. Adverse benefit determination notices will include:
    a. Discussion of the decision including, if applicable, an explanation of the basis for disagreeing with or not following:
        i. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
        ii. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
        iii. A Social Security Administration disability determination regarding the claimant, presented by the claimant to the Plan.
    b. 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 claimant's claim for benefits;

c. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

d. For appeal determinations, any contractual limitations period for filing a civil action and the calendar date deadline for doing so.

2. Before the Plan issues an adverse benefit determination on appeal, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Trustees, or their designee, or at the direction of the Trustees or their designee, in connection with the claim.
3. Before the Plan issues an adverse benefit determination on appeal based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale.
4. The term "adverse benefit determination" also means a rescission of disability coverage with respect to a participant or beneficiary whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time. For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.
5. To the extent required by applicable law, any notices will be provided in a culturally and linguistically appropriate manner.
6. To the extent the Plan violates any applicable claims and appeals procedures, a participant may request a written explanation of the violation from the Plan. The Plan will respond within 10 days.

GENERAL INFORMATION REGARDING PLAN ADMINISTRATION

The Trustees reserve the 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 you retire, 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 Trustees and/or their duly authorized designee(s) have the exclusive right, power, and authority, in their sole and absolute discretion, to administer, apply, and interpret the Plan, including this booklet, the Trust Agreement, and any other Plan documents, and to decide all matters arising in connection with the operation

or administration of the Plan. Without limiting the generality of the foregoing, the Trustees and/or their duly authorized designee(s) shall have the sole and absolute discretionary authority to:

1. Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
2. Formulate, interpret, and apply rules, regulations, and policies necessary to administer the Plan in accordance with its terms;
3. Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
4. Resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan, including this booklet, the Trust Agreement, or other Plan documents;
5. Process and approve or deny benefit claims; and
6. 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.

ADMINISTRATION

1. The Plan is administered by The Board of Trustees, which serves as the "Plan Administrator." The address of the Plan is:
   Joint Administrative Committee
   Board of Trustees
   DC 37 New York Public Library, 55 Water St., 22nd Floor, New York, NY 10041
   OR Health & Security Plan Trust, 445 5th Ave., New York, NY 10016
2. The Employer Identification Number issued to the Trust is 13-3307632. The Plan Number assigned to the Plan is 501.
3. The name and address of the entity designated as Agent for Service of Legal Process is:
   Joint Administrative Committee
   Board of Trustees
   DC 37 New York Public Library, 55 Water St., 22nd Floor, New York, NY 10041
   OR Health & Security Plan Trust, 445 5th Ave., New York, NY 10016

   Service of process may also be made upon any Plan Trustee.

PLAN YEAR

For purposes of maintaining the Plan's fiscal records, the year end date is June 30. This is also known as the Plan Year.

EMPLOYER CONTRIBUTIONS

All contributions to the Plan are made by the New York Public Library in accordance with the Collective Bargaining Agreement with DC 37, AFSCME, and from time to time may be renegotiated. A copy of any and all such agreements may be obtained by a member or beneficiary upon written request to the Joint Administrative Committee, and is available for examination by members and beneficiaries at both the Plan Office, and at the New York Public Library Employee Benefits Office, and every worksite where 50 or more employees work.

The Plan's requirements with respect to eligibility for participation, as well as circumstances that may result in loss of any benefits, are described in this booklet as follows:

1. Eligibility on page 6.
2. Loss of Eligibility on page 8.
3. Amendment and Termination, and Interpretation on page 55.

The summary of procedures for applying for benefits is on page 48.

Any Participant wishing to appeal a denial of a benefit in whole or in part should file a request for a review within the timing constraints described beginning on page 51.

REFUND DUE STATUS

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

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

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.

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, the Plan will notify the Participant in writing and request a written response.

Within 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, the Plan will notify the Hearing Officer who will send a written notice to the Participant 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 Participant 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 Participant should be placed on "Refund Due" status. The Plan Administrator has the power to place the eligible Participant on "Refund Due" status. The Plan Administrator will review the recommendation and if the record warrants placing the Participant in "Refund Due" status, the Participant will be notified in writing of the determination.

Any Participant 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 Participant placed in "Refund Due" status has the right to appeal by filing a written appeal to the Trustees within 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 Participant in writing.

The Plan Administrator will send written notice of "Refund Due" status to the affected Participant once per year. Where appropriate, the Trustees will have the power to sue the Participant for non-payment and any interest or fees that occurred.

PART V.

ERISA AND OTHER LAWS

PART V.

ERISA AND OTHER LAWS

This Welfare Benefit Plan was established as the result of a collective bargaining agreement between District Council 37, AFSCME (the "Union") and the New York Public Library. Its purpose is to provide health and other welfare benefits to members and their dependents. The Trustees, the New York Public Library, and the Union want you as a participant in the Plan to enjoy its benefits. This booklet describes the Plan and tells you and your beneficiary(ies) how to get more information about benefits offered under the Plan. The description of the claims and appeals procedure tells you how to apply for benefits and how to follow up, if necessary.

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), which 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 all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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 dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependent(s) 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 that affect your benefits under this Plan. The fact that a provider may recommend that a covered person receive a dental, vision, audiology, podiatry, or prescription service does not mean that the service will be deemed to be medically necessary, or 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 is medically necessary in terms of generally accepted standards and is for a covered benefit 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, the Union, 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 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 claims and appeals process of the Plan as described above. 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, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. You also may obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 that are on file with the H&S plan office.

CONTINUATION COVERAGE (COBRA)

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you also may become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Visit **www.HealthCare.gov** or call 1.800.318.2596 for more information. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The benefits available for continuation coverage are Dental, Vision Care, Podiatry, 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 H&S 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, also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, 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/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" hours 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 for 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 also will 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 of the following qualifying events:

1. The end of employment or reduction in hours of employment;
2. Death of the employee;
3. The employee's becoming entitled to Medicare Part A, Part B, or both;
4. Commencement of a bankruptcy proceeding with respect to the employer, within 30 days following the date coverage under the Plan ends due to the occurrence of any of these events.

For all other qualifying events (i.e., divorce or legal separation of the employee and spouse/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 60 days after the qualifying event occurs. The notice must be in writing and sent to COBRA Administrator, DC 37/ New York Public Library Health & Security Plan Trust, 55 Water St., 22nd Floor, New York, NY 10041, attn: Accounting Dept. 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 COBRA CONTINUATION COVERAGE IS 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 will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Each qualified beneficiary has 60 days from the later of the date of the loss of coverage because of the qualifying event, or 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, divorce or legal separation, dependent child losing eligibility, or a second qualifying event occurs during the initial period of coverage, COBRA continuation coverage lasts for up to 36 months.

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

1. **Disability Extension of Continuation Coverage:** The 18-month period of COBRA continuation coverage may be extended for up to an additional 11 months (for a total of up to 29 months of continuation coverage) if you or any family member covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage, provided that you notify the COBRA Administrator of the SSA determination within 60 days of the date of the determination and before the end of the initial 18-month continuation coverage period. The 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA coverage as a result of the same qualifying event, subject to this notice requirement. Notice must be sent to the COBRA Administrator.
2. **Second Qualifying Event Extension of 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 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 also is available to your dependent child when that child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you or your family member must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Administrator.

OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options, such as a spouse's plan, through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

ENROLLING IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER GROUP HEALTH PLAN COVERAGE ENDS

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of the month after your employment ends or the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **www.medicare.gov/medicare-and-you**.

EARLY TERMINATION OF CONTINUATION COVERAGE

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

1. 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 H&S Plan Office or you may contact the nearest Regional District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

KEEP THE PLAN INFORMED OF CHANGES

In order to protect your family's rights, you should keep the H&S 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 H&S Plan Office.

PRIVACY OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives covered employees, retirees, and covered dependents certain rights with respect to their health information, and it also imposes certain obligations on the Plan as a group health plan. These rights and obligations do not apply to disability or other non-health benefits provided under the 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) that the Plan is required to distribute to you. For a copy of the Notice, please contact the Plan Office at 212.815.1700, or go to the DC 37 website at **www.DC 37.net**. If you have questions about the privacy of your

health information, please contact the Privacy Officer. If you wish to file a complaint about a privacy issue, please contact the Privacy Officer at 212.786.5410. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

This Plan and its sponsor will not use or disclose information that is protected by HIPAA ("protected health information" or "PHI") except as necessary for treatment, payment, Plan operations and administration, or as otherwise permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the sponsor.

The Plan also hires professionals and other companies to assist in providing health care benefits. The Plan has required these entities, called "Business Associates," to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights under HIPAA with respect to benefits provided by that company. Some Business Associates of the Fund, such as any health care providers (doctors, pharmacies, and hospitals) will provide you with their own notices of privacy practices.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You have the right to request reasonable restrictions on disclosure of your protected health information, and to request confidential communications of your protected health information. You have the right to receive notice of certain breaches of your unsecured protected health information and a right to obtain a paper copy of the Plan's Notice of Privacy Practices. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Your "protected health information" is information about you, including demographic information that

1. 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
2. Relates to your past, present, or future physical or mental condition; or
3. Relates to the provision of health care to you; or
4. Relates to the past, present, or future payment for the provision of health care to you; and
5. 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:

1. 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 also may receive protected health information as necessary for the Board to perform its fiduciary and administrative duties as required by ERISA.

2. 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.
3. 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.
4. If the Board discloses to any of its agents or subcontractors any of your protected health information that it receives from the Plan, the Board will require the agent or subcontractor to agree to the same restrictions that govern the Board's use of disclosure of your protected health information under the Plan Documents.
5. 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.
6. 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.) Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.
7. 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.)
8. The Board will keep a written record of certain types of disclosures that it makes, if any, of your protected health information for reasons other than for your medical treatment, payment for that medical treatment, or health care operations, or with your written permission. This written disclosure record will include those types of disclosures made during at least the previous six years, except only disclosures made after April 14, 2003 must be listed. The Board will make this disclosure record available to the Plan so that the Plan can provide you, upon request, with a copy of that list of disclosures. (You should review the Notice of Privacy Practices to learn more about your rights to request a log of certain types of disclosures of your protected health information made by the Plan.)
9. 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.
10. 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.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities may include, but are not limited to, the following:

1. Determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and Copayments as determined for an individual's claim),
2. Coordination of benefits,
3. Enrollment,
4. Remittance and contribution accounting,
5. Collection of W-9 information from Providers,
6. COBRA and HIPAA administration,
7. Adjudication of health benefit claims (including appeals and other payment disputes),
8. Subrogation of health benefit claims,
9. Establishing contribution rates for contributing employers,
10. Establishing employee contributions,
11. Risk adjusting amounts due based on enrollee health status and demographic characteristics,
12. Billing, collection activities and related health care data processing,
13. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Covered Employee or Retiree inquiries about payments,
14. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance),
15. Medical Necessity reviews, or reviews of appropriateness of care or justification of charges,
16. Utilization review, including pre-authorization, concurrent review and retrospective review,
17. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, DJL number, payment history, account number, and name and address of the Provider and/or health plan), and
18. Reimbursement of individual overpayments to the Plan.

"Health Care Operations" may include, but are not limited to, the following activities:

1. Quality Assessment,
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, or contacting of health care Providers and patients with information about treatment alternatives and related functions,

3. Rating Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration and development or improvement of methods of payment or coverage policies,
7. Business management and general administrative activities of the Plan, including, but not limited to:
    a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
    b. Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers,
    c. Resolution of internal grievances, and
    d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
8. Compliance with and preparation of all documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs, and other documents.

The Plan will also use and disclose PHI as required by law and as permitted by authorization of the Covered Employee or Retiree or Covered Dependent.

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.

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

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

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

The Plan Sponsor will report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of electronic PHI or interference with system operations in its information system in which the electronic PHI is maintained.

The Plan Sponsor will comply with any other requirements that the Secretary of the HHS may require from time to time with respect to PHI or electronic PHI by the issuance of additional regulations or other guidance pursuant to HIPAA.

The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

If "unsecured" PHI is accessed, acquired, used or disclosed in a manner that is not permitted under the HIPAA privacy rules, the Privacy Officer will presume that a breach of unsecured PHI has occurred unless a risk assessment, conducted in accordance with the Fund's procedures, determines that there is a low probability that the PHI has been compromised. If the Privacy Officer determines there has been a breach of unsecured PHI, the Plan will provide notification as required by law and in accordance with its procedures. "Unsecured PHI" is PHI that has not been rendered unusable, unreadable, or indecipherable through the use of a technology or methodology specified by HHS. A "breach of unsecured PHI" means the acquisition, access, use or disclosure of unsecured PHI in a manner that is not permitted by the HIPAA privacy rules, and that compromises the security or privacy of the PHI.

DISTRICT COUNCIL 37/NEW YORK PUBLIC LIBRARY 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: The District Council 37 Health & Security Plan Inquiry Unit 55 Water St., 22nd Floor, New York, NY 10041, 212.815.1234 or contact the Privacy Officer, Jodi Goldman, Esq., Associate Administrator, at 55 Water St., 22nd Floor, New York, NY 10041. She also can be reached via phone at 212.815.1390, or email at jgoldman@DC 37.net

Effective Date: Sept. 2022

The DC 37/New York Public Library 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 except the Municipal Employees Legal Services benefit (MELS).

As MELS does not perform functions related to health care, MELS's operations will be separate from those of the Plan, and MELS will not need to comply with HIPAA, 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 & Security Plan Inquiry Unit, 55 Water St., 22nd Floor, New York, NY 10041, or at 212.815.1234. 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 60 days of that type of change.

This notice is general in nature, and 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 an electronic or paper copy of your health and claims records
- Ask us to correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share, such as certain health information for treatment, payment, or our operations
- 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, such as a medical power of attorney or a legal guardian
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way we use and share your information, such as:

- Sharing information with your family and friends, or others involved in your care
- Sharing information in order to provide disaster relief
- Marketing our services, selling your information, and sharing of psychotherapy notes

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.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- 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 SHARE OR USE

- 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.
- You can request 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 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 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 BELIEVE YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us using the information on page 3.
- 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 Ave., S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting **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 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. For 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. For example, we use health informatoin 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. For 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. For example, your employer contracts with us to provide a health plan, and we provide your employer with certain statistics to explain the premiums we charge.

HOW ELSE 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**.

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 Department of Health Article 27F 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 provide you with a copy.
- We will not use or share your information other than as described here unless you tell us in writing that we can. You may change your mind at any time by letting us know in writing .

For more information see 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 website, 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 Unformed 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 member's share for that coverage if the period of military service does not exceed 31 days. If the period extends beyond 31 days, the member may be required to pay not more than 102% of the full premium under the plan.

Special circumstances may entitle you to continue your eligibility for coverage under the Plan when you are on leave from work due to service in the uniformed services of the United States.

NOTE: In order to be eligible for continued coverage as provided below, your Employer must properly grant the leave and make the required notification and payment to the Fund. Please contact your Employer to determine whether you are eligible.

The general rules are set forth below:

If you are on active military duty for a period of 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active military duty for more than 31 days, USERRA permits you to continue medical, dental, vision, and prescription drug coverage for you and your dependents **at your own expense** for up to 24 months. This continuation right operates in the same way as COBRA. See pages 62-66 for a full explanation of the COBRA coverage provisions. In addition, your dependent(s) may be eligible for health care coverage under TRICARE, the military health system. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from service in the Uniformed Services, your full eligibility will be reinstated on the day you return to covered employment, provided that you return to employment:

- Within 90 days from the date of discharge if the period of service was more than 180 days; or
- Within 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- At the beginning of the first, full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

If you have any questions about taking a leave of absence, please speak directly with your employer. If you have any questions about how a leave of absence affects your coverage, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

NOTES

NOTES

District Council 37-New York Public Library Health & Security Plan Trust

H&S Plan Office:
55 Water Street, 22nd Floor
New York, NY 10041
212.815.1234