

DOCTORS COUNCIL BENEFIT PLAN

BENEFIT BOOKLET

DOCTORS COUNCIL BENEFIT PLAN -PLAN OFFICE

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Dear Member:

We are pleased to provide you with this updated benefit booklet summarizing benefits provided by the Doctors Council Benefit Plan. **These benefits are provided at no cost to you and are funded through contributions made to the Plan by your Employer.**

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

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

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

Sincerely,

Board of Trustees

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ELIGIBILITY

Who Is Eligible for Coverage?

You are eligible for the benefits described in this booklet if you are represented by the Doctors Council for collective bargaining purposes, and are regularly employed by the following employers for the number of hours set forth below:

1. New York University School of Medicine at Woodhull Hospital
All employees who work at least 8 hours per week. Employees who work at least 16 hours per week receive full-time benefits; employees who work at least 8, but less than 16 hours per week receive part-time benefits.
2. PAGNY at Coney Island Hospital
All employees who work at least 8 hours per week. Employees who work at least 20 hours per week receive full-time benefits; employees who work at least 8, but less than 20 hours per week receive part-time benefits.
3. The following dependents are also eligible to receive benefits:
 - a. your lawful spouse or domestic partner; and
 - b. any unmarried children/grandchildren of yours who qualify as dependents under the Internal Revenue Code who are
 - i. less than 19 years old; or
 - ii. 19 years and up to age 26 under the Affordable Care Act with the completion of the Special Enrollment Form.
 - iii. children who, regardless of age, are unable to support themselves due to mental illness, developmental disability, mental retardation, or physical handicap provided such incapacity began before age 19.

What if I have a change in Dependent Status?

If you have a change in dependent status (whether adding a dependent to your coverage or removing a dependent previously insured) you must notify the Plan Office within 30 days of the event. If you do not elect to cover a new dependent within the 30 day notification period, the effective date of coverage will be the date that the notification is received by the Plan Office.

You may add or drop an eligible dependent from coverage effective on the date that any one of the following qualified changes in family status occurs:

- Marriage, divorce, or legal separation;
- Birth or adoption of a child;
- A significant change in your spouse/ domestic partner's benefits attributable to your spouse/ domestic partner's employment;
- Death of a spouse or child; or
- You are no longer an eligible employee due to failure to meet the eligibility requirements on page

What is the Plan Year?

The Plan Year is any January 1 to December 31. Many benefit maximums are determined on the basis of Plan Year.

When Does Coverage Become Effective?

Coverage begins on the first day of employment with your employer.

When Does Coverage Terminate?

Coverage will cease on the earliest date below:

1. the date you cease to meet the eligibility criteria,
2. the date of termination of your employment,
3. the date your employer's participation in the Plan is discontinued, or
4. the date of termination of the Plan.

Your dependent will cease to be covered on the earliest date below:

1. the date of discontinuance of the member's coverage, or

2. the date your dependent ceases to be eligible under the definition of the term “dependent” as described later in this booklet.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you enter the Armed Forces, you will be offered the opportunity to continue coverage under the Plan for yourself and your dependents on a self-pay basis pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) for a period of up to 18 months during your military service. If the period of military service is less than 31 days, your coverage (and your dependents’ coverage, if applicable) will continue during the 31 days without charge. If you do not elect to continue coverage (and your dependents’ coverage, if applicable) during the period of military service, you are entitled to have your coverage reinstated on the date you return to covered employment with one of the Contributing Employers. No exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably. Contact the Plan Office for further details regarding your rights and obligations under USERRA.

COORDINATION OF BENEFITS

Your coverage under this Plan has a Coordination of Benefits provision.

Coordination of benefits is a feature of many insurance programs. Frequently, a family's coverage overlaps. For example, you and your spouse may both be insured by two plans if you are covered by different group insurance plans sponsored by different employers.

You are required to inform the Plan Office of any additional coverage and submit copies of all documentation related to any claim filed with the Plan Office and with any other insurance plan.

The "primary" plan - usually the one that covers you as an employee - is the first plan to pay benefits. The "secondary" plan - usually covering you as a dependent - would then pay any difference between the actual charges and what the primary plan provides.

This provision automatically applies if you have insurance coverage provided by more than one plan. This also includes your own private insurance and no-fault insurance, both of which will always be primary to this Benefit Plan coverage. If this is the case, then the benefits available from any other plan will be taken into account when figuring the benefits provided by this Plan. In other words, the Coordination of Benefits provision may require a reduction in benefits under this Plan so that the combined benefits available under two different plans will not be more than your actual expenses.

For claims for dependent children, this Plan utilizes the "Birthday Rule" for Coordination of Benefits. If each parent is covered by an employer-sponsored plan, the primary payer for the child is the plan of the parent whose birthday falls earlier in the year.

CLAIM FILING PROCEDURES

This section includes the following:

- Claim Filing Procedure
- Claim Review

Claim Filing Procedure:

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

ALL CLAIMS SENT TO THE BENEFIT PLAN MUST BE POSTMARKED NO LATER THAN ONE YEAR (365 DAYS) FROM THE DATE SERVICE IS RENDERED, EXCEPT AS OUTLINED BELOW. FAILURE TO SUBMIT CLAIMS WITHIN THESE TIME DEADLINES WILL RESULT IN REJECTION OF THE CLAIM. THERE WILL BE NO PAYMENT BY THE BENEFIT PLAN ON LATE CLAIMS.

- Healthcare Cost Reimbursement Benefit Claims: **Must be postmarked no later than December 31st in the year following the end of the Plan Year (December 31st) to which the claim relates.**
- Disability Claims (initial application): **Must be postmarked within three weeks of the onset of disability.** Failure to file within this period will result in the extension of the member's unpaid waiting period.
- Disability Claims (follow-up reports): **The member must submit monthly follow-up reports to be completed by the member and his/her physician. Failure to file will result in non-payment.**

Claim Review:

There is a claim review procedure to follow if your claim for a benefit is denied. See the section in this booklet entitled “Other Important Information” for more details.

BENEFITS

CHIROPRACTIC BENEFIT

Member, spouse or domestic partner and eligible dependents are each entitled to reimbursement of \$25 per chiropractic visit for up to 10 visits every Plan Year (January 1 - December 31).

How Do You File Claims?

To file a claim for this benefit, obtain a claim form from the Plan Office. Complete the claim form, attach an itemized bill from the chiropractic visit stating the name of patient and date of services rendered and return the claim form to the Benefit Plan Office within **one (1) year** from the date of the visit for which you seek reimbursement. This benefit is in addition to any other coverage you have including Medicare.

HEALTHCARE COST REIMBURSEMENT BENEFIT

An annual combined medical and dental deductible or co-payment reimbursement benefit of **\$600** per family for full-time eligibles/dependents and **\$300** single, and **\$300** per family for part-time eligibles/dependents and **\$150** single will be paid to you for expenses incurred in the Plan Year (January 1 - December 31) for medical, hospital and dental deductibles and co-payments under Medicare and/or your group medical/surgical and hospital insurers, prescription drug deductibles or co-payments under your group medical/surgical and hospital insurers, charges incurred for health services covered in a member's existing coverage that exceed the reimbursement received (including services covered under the Doctors Council Benefit Plan), and premiums for Medicare Part "B", Medigap and other out-of-pocket healthcare coverage either for yourself or an eligible dependent. The maximum amount of deductible/co-payment reimbursement per year for a family is **\$600** for full-time eligibles and **\$300** for part-time eligibles. You must submit a copy of the Explanation of Benefits form(s) from the insurance plan which documents the out-of-pocket expenses you have incurred for deductibles/co-payments during that year. Do not submit the forms until you have met the full amount of the deductible benefit you are eligible to receive that year and no later than December 31 of the following calendar year. The Plan will only process one claim for this benefit per member in each Plan Year.

DISABILITY BENEFIT

Members are eligible to receive weekly income for a period of up to 60 days if they are TOTALLY DISABLED as the result of an illness or injury. Total disability means that you are under the regular care of a licensed physician and that you are TOTALLY UNABLE TO PERFORM THE DUTIES OF YOUR PROFESSION. This benefit is not available to your spouse or dependents.

When Do Benefits Become Payable?

Disability benefits under this Plan begin the first day following the 30 day waiting period (after you have been TOTALLY DISABLED for 30 consecutive days) and continue up to the 90th day of that single occurrence of disability. Successive disability periods separated by less than 2 weeks of continuous active employment in your profession are considered one continuous period of disability unless they arise from different and unrelated causes. Benefits are limited to 120 days per Plan Year.

What Is Your Benefit?

If you qualify for full-time benefits, your gross weekly disability benefit is \$200.

If you qualify for part-time benefits, your gross weekly disability benefit is \$100.

This amount is in addition to any other disability benefits you may be eligible for through Social Security, private insurance or statutory disability (DBL).

Benefits are provided for a maximum of sixty (60) days per occurrence of disability for a maximum of 120 days per Plan Year.

You do not receive benefits for the waiting period.

When Do Benefits Stop?

Benefits cease when you retire from active employment, after 60 days of payments, or when you are no longer disabled as defined above, whichever occurs first. If you receive disability payment after your date of retirement, you are required to reimburse the Plan.

What Is Not Covered?

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

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

How Do You Claim Your Disability Benefits?

Initial Application

If you are totally unable to perform the duties of your profession and are under a doctor's care, you and your doctor must complete and submit claim forms which are available from the Plan office describing your disability. Both the member's and the physician's claim forms must be postmarked WITHIN 3 WEEKS (21 days) of the onset of the disability. Failure to file within this period will result in the extension of the member's unpaid waiting period by the additional time between the 3 week filing deadline and the actual time of receipt of the claim. (For example: if the onset of the disability was January 1, and the claim was received February 15, 24 days of non-payment of benefit would be added onto the 30-day waiting period extending the member's period of non-payment to seven weeks and five days, February 25.) Your doctor must submit the physician's disability claim form and detailed medical records with supporting documentation of your disability within the 3 week period for the application to be timely.

Follow-Up Reports

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

THE PLAN RESERVES THE RIGHT TO OBTAIN AN INDEPENDENT MEDICAL EXAMINATION AND APPROPRIATE TEST RESULTS. FAILURE TO TAKE THIS

EXAMINATION WHEN REQUESTED, OR FAILURE TO BE EXAMINED IN A TIMELY FASHION MAY RESULT IN DENIAL OF YOUR CLAIM.

HEARING AID BENEFIT

Under this benefit, members and dependents are eligible for reimbursement once every two years for the purchase, repair and maintenance of hearing aids (batteries are not included) and for a hearing examination not covered by Medicare or any other insurance. A reimbursement for a second hearing aid will be provided if necessary.

Full-time	\$1500 Per Person
Part-Time	\$750 Per Person

Covered Hearing Aid expenses are: cost of installation of a hearing aid that was provided subsequent to the date of a written recommendation by an Otolaryngologist (ENT) or Otologist or Audiologist and the cost of a hearing examination by an Otolaryngologist (ENT) or Otologist or Audiologist if it is given with the intent or purpose of prescribing a hearing aid.

What Is Not Covered?

1. a hearing aid not recommended by an Otolaryngologist (ENT) or Otologist or Audiologist,
2. expenses for which benefits are payable under any Workers' Compensation Law,
3. charges for services or supplies which are covered in whole or in part under any other plan.

How Do You File Claims?

Obtain a claim form from the Plan Office. Take this form with you when you go for an appointment. Complete the member's portion and have your physician complete the physician's portion. Attach the itemized bill reflecting payment for the hearing aid to this form, and return it to the Plan Office within **one (1) year** from the date the services were rendered. The bill must be itemized and describe the appliance purchased, the amount charged, the name of the person who

required the hearing appliance, and the Otolaryngologist (ENT) or Otologist or Audiologist authorization or certification.

The hearing examination must be performed and the certification completed and signed by an Otolaryngologist (ENT) or Otologist or Audiologist. The Benefit Plan will not honor the claim if the member or dependent has had the services rendered by an audiologist or any practitioner other than an Otologist or Otolaryngologist (ENT).

HOSPITAL INDEMNITY BENEFIT

This benefit provides reimbursement to members only for each day of confinement in an acute care hospital up to a maximum of 30 days during each Plan Year (January 1 -December 31).

Full-time \$60 per day

Part-time \$30 per day

How Do You File Claims?

To file a claim for this benefit, obtain a claim form from the Plan Office. Complete the claim form and attach an itemized bill from the hospital stating the name of patient and date of admission and discharge. This benefit is in addition to any other coverage you have including Medicare. You must file claims within **one (1) year** after your hospital discharge.

LEGAL SERVICES BENEFIT

New York State Residents

This section includes the following:

- Benefit Description
- Exclusions
- Filing Procedure

Benefit Description:

The legal services covered by the Plan are limited to those which can be provided by lawyers admitted to practice in the state of New York. The law firm of Pryor Cashman LLP, 7 Times Square, New York, New York 10036-6569 has been retained for the purpose of providing the legal services benefit, and all matters will be handled confidentially on an attorney-client basis. Reference to a covered doctor's dependents means those spouses who qualify as dependents under the Internal Revenue Code, and domestic partners recognized by an appropriate governmental agency to be eligible to receive domestic partner benefits. Each covered doctor is responsible for reimbursing the law firm directly for expenses (e.g., toll calls, photocopies, transportation, filing fees, etc.) for services performed on behalf of the doctor or his/her spouse or domestic partner. No expense over \$75 will be incurred without the doctor's prior knowledge and approval. The law firm will require payment of an advance against disbursements for expenses and legal fees of up to **\$7,000** for all matters.

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

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

the Plan, a fee of **\$1,150** will be payable. For example, a member selling one residence and purchasing another any time within two years of the closing of sale would pay a fee of **\$425** for the first transaction and **\$800** for the second transaction.

- MATRIMONIAL: An uncontested divorce involving a covered doctor for a fixed fee of **\$500**;
- ADOPTION: An uncontested adoption, where a covered doctor is an adoptive parent for a fixed fee of **\$500**;
- NAME CHANGE: A change of name of a covered doctor, spouse/domestic partner or dependent for a fixed fee of **\$500**;
- CRIMINAL DEFENSE: Defense in a criminal prosecution, up to and through the point of arraignment, for a covered doctor, spouse or domestic partner for a fixed fee of **\$500**;
- GENERAL CONSULTATION/ REPRESENTATION: In each plan year, two hours of general consultation (without charge to the participant) or other legal services on behalf of a covered doctor, spouse or domestic partner concerning any legal matter (without charge to the participant), except those covered under the Plan on a contributory basis or excluded below, and up to fifty (50) additional hours at a reduced hourly rate of **\$180** (payable by the covered doctor);
- STATE LICENSE PROCEEDINGS: Representation of a covered doctor in a proceeding initiated by a New York State administrative agency which may result in the suspension or revocation of the doctor's

license at a reduced hourly rate of **\$180** (payable by the covered doctor) for up to fifty (50) hours (not including the initial two hours without charge if not already used during the plan year);

ESTATE

ADMINISTRATION:

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

ESTATE PLANNING:

Drafting and settlement of a will or codicil (any amendment to a will), including power of attorney, living wills and health care proxies for a covered doctor, spouse or domestic partner at a single charge of **\$450** to the doctor; an **\$800** fee covers services for both the eligible doctor and spouse or domestic partner, provided that the estate planning and preparation and execution of the wills are undertaken concurrently; in the case of complex estate planning, documents such as an insurance trust or inter vivos trust related to estate planning will be prepared for an additional charge of **\$300** per document. A real estate transfer related to estate planning will be treated as a real estate transaction under the Plan.

PERSONAL INJURY:

Personal injury and property damage actions on behalf of a covered doctor and his/her dependents at a contingency fee

of 25% of any recovery; the legal service provider reserves the right to reject proceeding on a contingency fee basis.

Exclusions:

The following matters are not covered under this Plan:

- Matters involving controversy or a conflict with the City of New York, the New York City Health and Hospitals Corporation, or the New York City Transit Authority, or otherwise arising out of your employment under a Doctors Council contract, except for a proceeding initiated by a State administrative agency which may result in the suspension or revocation of a member's license;
- Legal services required in any matter not specifically stated above over the specified hours covered under the Plan. Upon the exhaustion of those hours, the member may, at his or her option, retain the firm at its regular rates or obtain other counsel; and
- Representation of an individual otherwise eligible for the Plan who is not current on his/her payments to the law firm. The law firm reserves the right to withdraw from representation on pending matters when an individual is not current on his/her payments to the firm.

Filing Procedure:

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

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

Out-of-State Residents

Members who reside outside of the State of New York are eligible only for the out-of-state Legal Services Plan (LSP) unless they expressly opt to join the In-State Legal Services Plan. In order to choose the In-State LSP, a member must notify the Plan Office in writing prior to the beginning of the Plan Year that he/she wishes to be a participant in the In-State LSP for the coming year, and until further notice. In order to be covered for the out-of-state LSP a member must have his/her primary residence outside of the State of New York.

The out-of-state LSP provides up to **\$600** reimbursement for fees paid for either the preparation of a will for member or spouse OR a real estate closing on the primary residence once each Plan Year (January 1 - December 31). Claim forms can be obtained by contacting the Plan Office. By participating in the in-state LSP, members forego participation in the out-of-state LSP.

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

How Do I Receive These Benefits?

You must call the Benefit Plan Office directly at (212) 532-7690. The Benefit Plan Office will then determine whether you are a covered member and advise the law firm accordingly or send you the appropriate reimbursement forms if you participate in the out-of-state LSP. You will not be asked about the nature of the legal matter by an employee of the Plan if you participate in the in-state LSP.

Do not call the lawyers' office. They can provide no services until they receive certification from the Benefit Plan Office indicating that you are covered.

OPTICAL BENEFIT

Member, spouse and eligible dependents are each entitled to reimbursement once every Plan Year (January 1 - December 31) for prescription eyeglasses, contact lenses and eye examinations of \$300 per person Full-time or \$150 per person Part-time, **OR** receive an eye exam and glasses or contact lenses from the participating provider network under CPS Optical at no cost. **If you choose the services from a participating provider you must contact the Plan Office first to verify eligibility and obtain an optical service voucher.**

Exclusions under this benefit are:

1. expenses for which benefits are payable under any Workers' Compensation Law,
2. medical or surgical treatment of the eye or eyes.

How Do You File Claims?

To file a claim for this benefit, obtain a claim form from the Plan Office. Complete the claim form and attach a copy of your itemized receipt and return the claim forms to the Plan Office within **one (1) year** from the date service was completed. **If an eye examination was given, you must also submit a copy of your rejection or payment voucher from your other health insurance.**

SELF-PAID CONTINUATION OF COVERAGE (COBRA)

1. You and/or your eligible dependent(s), spouse or child(ren) have the right to continue health care coverage under the Plan if coverage terminates for certain reasons. *(In addition to COBRA, you may be eligible to continue coverage if your coverage terminates because you enter the armed forces. See page 3.)* The continuation coverage is available in the event your coverage or that of a dependent terminates due to:
 - a. Termination of your employment for any reason, including retirement, except gross misconduct;
 - b. Loss of your eligibility for benefits due to reduced work hours;
 - c. Your death;
 - d. Your divorce or legal separation;
 - e. A dependent child ceasing to be a dependent, as defined on page 1. A child eligible to be continued under the health plan's handicapped child provisions will continue to be a covered dependent;
 - f. A dependent's loss of eligibility because you become entitled to Medicare benefits.

2. It is important that you notify the Plan Office immediately when any of the events set forth above, which would otherwise terminate Plan coverage, occurs. If one of your dependents would lose coverage for the reason set forth above as event "d", "e" or "f", you or your dependent must notify the Plan Office of the event so that the Plan Administrator can give appropriate notice of continuation rights and terms which apply to the continuation. Failure to advise the Plan Office within sixty (60) days of your divorce or the event which caused a dependent to cease to be a covered dependent under the Doctors Council Benefit Plan will result in the forfeiture of your dependents' right to continuation coverage.

3. Coverage will not be continued beyond the earliest to occur of:
 - a. Failure to pay the required premium on time;
 - b. The date the individual becomes covered under another employer-funded group health plan either as an employee or dependent unless the individual has a pre-existing condition which the other plan will not cover. In that event the individual (and eligible dependents) may be allowed to continue his or her COBRA coverage for the applicable maximum period. Contact the Plan Administrator for details;
 - c. The date the individual becomes entitled to Medicare;
 - d. The date the group health plan terminates as to the eligible group of which you were a member. If the coverage is replaced, you may be continued under the new coverage;
 - e. 18 months (maximum) from the qualifying event if coverage is being continued for a member, spouse or domestic partner or dependent because the member ceased covered employment or lost eligibility due to reduced hours. This may be extended to 29 months in the case of a determination of disability by the Social Security Administration. Contact the Plan Administrator immediately for details if you are disabled;
 - f. 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or domestic partner or dependent for a reason other than the member's loss of coverage due to a termination in covered employment or reduction in hours.
4. The Benefit Plan will set premium payments for continued coverage according to federal law, which provides that the COBRA premium may cover the full cost to the Plan for the benefits plus administrative expenses. If the cost changes, the Benefit Plan will revise the charge you are required to pay.

Full details of the continuation and payment schedule will be furnished to you or your dependents when one of the events in item 1 shown above occurs. If you have any questions regarding this coverage, please call the Benefit Plan Office.

OTHER IMPORTANT INFORMATION

Claim Review Procedures

If you file a claim and receive a decision with which you disagree, you have the right to have your claim reviewed by the Board of Trustees by writing to the Plan Administrator whose address is listed at the beginning of this booklet.

Either you or your beneficiary may write to the Plan Administrator. You should state the nature of the claim and provide other relevant information. The Trustees will make a decision about your claim. In most cases you will be notified in writing of that decision within 90 days of your request for reconsideration. If a claim is denied, in whole or in part, the Plan Administrator will tell you:

1. the specific reasons for the denial,
2. the Plan provision(s) on which the Trustees' decision was based,
3. what additional material or information is required for any further review of your case where appropriate; and
- 4) what procedure you should follow to obtain further review where that is appropriate.

If a claim is denied by the Trustees, you have the right to reapply for a review. You must do this in writing within 60 days after you receive or were eligible to receive the claim denial notice. Your request for review may include any additional information that you wish to supply.

After receiving this request, the Trustees will again review your claim. If you wish, you may also review any documents the Plan Administrator has that concern your request, such as copies of the Plan or special information relating to your claim.

The Trustees will usually make a final decision on your claim within 60 days after receiving your review request. However, if special circumstances arise, the Trustees may require additional time to fully consider your claim. The final decision will be in writing, clearly stating the reasons for the decision and the provisions of the Plan upon which the decision was based. If you do not receive a decision within the time limits described above, you should consider your claim to have been denied.

STATEMENT OF ERISA RIGHTS

Your Rights Under ERISA:

1. As a participant in this Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
 - (a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
 - (b) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
 - (c) 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.
2. 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.
3. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

4. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
5. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.
6. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
7. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the 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 person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim frivolous).
8. If you have any questions about the Plan, you should contact the Plan Administrator.
9. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

ADDITIONAL INFORMATION

The information in this booklet contains only a summary of the features of your coverage. This booklet is not a contract. The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Office, and is available for examination by participants and beneficiaries as required by applicable law. Participants and beneficiaries may receive from the Plan Office, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

The Board of Trustees has been designated as the agent for the service of legal process. Process can be made at the Plan Office.

The following benefits are underwritten by Doctors Council Benefit Plan on a self-insured basis:

- Chiropractic
- Disability Benefit
- Deductible/Co-payment Reimbursement Benefit
- Hearing Aid Benefit
- Hospital Indemnity Benefit
- Legal Services Benefit
- Optical Benefit

Benefits are provided from the Plan's assets which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered members and defraying reasonable administrative expenses.

The Plan's assets and reserves are held in trust by the Board of Trustees of the Doctors Council Benefit Plan.

As someone who is eligible for benefits from this Plan, you are no doubt aware of the fact that the benefits are paid in accordance with Plan provisions out of a Trust Fund which is

used solely for that purpose. If you have any questions or problems relating to benefit payments, you have the right to obtain answers from the Trustees who administer the Plan.

The Plan Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of members working under the Collective Bargaining Agreement.

Plan Sponsor:	Board of Trustees of the Doctors Council Benefit Plan
EIN Number Assigned by the Internal Revenue Service:	13-3387038
Official Name of the Plan:	Doctors Council Benefit Plan
Plan Number:	501
Plan Administrator:	Board of Trustees of the Doctors Council Benefit Plan 50 Broadway, 11 th Floor, Suite 1101 New York, New York 10004 (212) 532-7690 (212) 481-4137 (fax)
Agent for Service of Legal Process:	Plan Administrator, at the address set forth above. Service of legal process may also be made upon a Plan Trustee at the same address.
Type of Plan:	Welfare benefit plan providing supplemental medical, vision, and disability, as well as legal services benefits.
Trust Fund:	The assets of the Plan are held in a trust fund established and maintained under the Agreement and Declaration of Trust of the Doctors Council Benefit Plan.
Plan Year:	January 1 – December 31.

IMPORTANT NOTICE

This booklet describes your benefits. Do not rely on statements made by any individuals. The only authorized information concerning your benefits must be in writing from the Board of Trustees acting in their official capacity. If you have any questions, write to the Plan Office and you will receive a written response.

The Trustees reserve the right to change or discontinue: (1) the types and amounts of benefits under this Plan, and (2) the eligibility rules.

PLAN TERMINATION

The Trustees intend to continue the Plan described in this booklet indefinitely. Nevertheless, they reserve the right, subject to the provisions of any pertinent Collective Bargaining Agreement, to terminate the Plan. The Plan may be terminated in writing by the Trustees when there is no longer in effect an agreement between an Employer and the Union requiring payment to the Plan. Upon termination of the Plan, the Trustees shall apply the monies of the Plan to provide benefits or otherwise to carry out the purposes of the Plan, as evident in this booklet and insurance contracts, in an equitable manner until the entire remainder of the Trust Fund has been disbursed.

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