

BENEFIT BOOKLET

**DOCTORS COUNCIL
RETIREE WELFARE FUND**

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Dear Retiree:

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

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

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

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

Sincerely,

Board of Trustees

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INTRODUCTION

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

- 1) File your benefits on time. The Doctors Council Retiree Welfare Fund must receive the required documents postmarked no later than **one (1) year** from the date of service unless expressly provided otherwise for a particular benefit. If you believe that your claim will be late, contact the Fund office in writing before the 180th day after the date of service for further instructions;
- 2) Notify the Fund Office at once if there is a change in your family status. (See “Changes in Enrollment” section).
- 3) Provide all information requested to prevent delay in processing your claim;
- 4) Review the description of benefits carefully, especially benefit exceptions and exclusions;
- 5) Read all information sent to you by the Fund Office and respond to all requests in a timely fashion.

MEMBER ELIGIBILITY

This section includes the following:

- Eligibility Requirements
- Effective Coverage Date

Eligibility Requirements:

Generally you are eligible for the benefits described in this booklet if you retired from employment with the City or the Health and Hospitals Corporation after June 30, 1970, and you were eligible for Doctors Council Welfare Fund coverage while you were employed.

The specific requirements for eligibility are the following:

- You must either be a primary beneficiary of the New York City Health Insurance program, or
- A Retiree receiving payments from the New York City Employees' Retirement System (NYCERS) who completed five years of full-time service with the City or the Health and Hospitals Corporation.

Effective Coverage Date:

You become eligible for benefits after you are certified by the City and after the Doctors Council Retiree Welfare Fund receives a contribution on your behalf. However, if you can prove your eligibility before certification and before contributions are made on your behalf by the City or the Health and Hospitals Corporation, coverage will begin at that time.

DEPENDENT COVERAGE

This section includes the following:

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

Dependent Eligibility:

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

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

Revenue Code, the Internal Revenue Service currently treats as imputed income to you the value of the benefits coverage provided to domestic partners. You are advised to review the consequences of electing this benefit with your own tax advisor.

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

Qualified Medical Child Support Orders (QMCSO):

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

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

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

Extension of Dependent Coverage:

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

Changes in family status or family circumstances:

- The Fund Office should be notified promptly when any change occurs in your family status such as: marriage, divorce, separation, termination/initiation of domestic partnership, birth or adoption of a child, or death of the member or death of an eligible dependent. The retiree or dependent(s) must notify the Fund in writing within 30 days of the change.
- The retiree or dependent must notify the Fund within 30 days from the date of any change of name and/or address.
- For dependent(s) for whom you have formerly declined enrollment because of other health insurance coverage, you may enroll these dependent(s) in the plan within 30 days from the date the other insurance coverage ceases.

BENEFIT COST

The benefits described in this booklet are provided without cost to you as the primary beneficiary. The City of New York and the New York City Health and Hospitals Corporation pay the entire cost through contributions under the Doctors Council collective bargaining agreement. When your dependents cease to be eligible for benefits, you or they must contact the Fund Office for information about continuation of benefits on a self-paid basis. See “COBRA Coverage” section.

COORDINATION OF BENEFITS

This section includes the following:

- Definition of Coordination of Benefits
- Determination of Benefit Payments
- Medicare

Definition of Coordination of Benefits:

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

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

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

Determination of Benefit Payment:

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

- The plan without a coordination of benefits provision.
- Where both plans have a coordination of benefits provision, the plan that covers a person as a member, rather than as a dependent.
- If the Doctors Council Retiree Welfare Fund covers both you and your spouse as members, you will receive payment first as a member and second as a dependent.

- In the case of a dependent child, the plan of the parent whose birthday occurs earlier in a calendar year pays first. If both parents have the same birthday, the plan which has covered the parent longer, will pay first.
- If you are separated or divorced, there are special rules regarding coverage for your children. If a court order establishes responsibility for the health care expenses of your children, benefits are paid according to that order. If there is no court order, benefits are paid in the following order:

Parents separated or divorced:

- 1) The plan of the parent/stepparent having custody of the child.
- 2) The plan of the parent/stepparent not having custody of the child.

Medicare:

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If Medicare and this plan cover you, and/or your eligible dependents, then Medicare pays first and this plan pays second for covered benefits.

CLAIM FILING PROCEDURE

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.**

CLAIMS SENT TO THE RETIREE WELFARE FUND MUST BE POST-MARKED NO LATER THAN ONE(1) YEAR FROM THE DATE SERVICE IS RENDERED, EXCEPT HEALTHCARE COST REIMBURSEMENT BENEFIT WHICH MUST BE POSTMARKED NO LATER THAN JUNE 30TH OF THE FOLLOWING PLAN YEAR (Plan Year is July 1 through June 30). FAILURE TO SUBMIT CLAIMS WITHIN THESE TIME DEADLINES WILL RESULT IN REJECTION OF THE CLAIM. THERE WILL BE NO PAYMENT BY THE RETIREE WELFARE FUND ON LATE CLAIMS. MEMBERS HAVE A MAXIMUM OF TWO YEARS FROM THE DATE OF SERVICE TO SUBMIT VERIFICATION THAT THE CLAIMS WERE SUBMITTED TO THE MEMBER'S PRIMARY BENEFIT CARRIER.

Claim Review:

If your claim is denied, there is a claim review procedure. See "Review Process" section for details.

BLOOD BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

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

Claim Filing Procedure:

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

- (a) Complete the claim form,
- (b) Attach a copy of your hospital bill,
- (c) Attach proof of out-of-pocket expenses,
- (d) Return the claim form to the Fund Office with the required attachments within 1 Year from the date you were discharged from the hospital.

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

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have.

For a complete description of your coordination of benefit provision, please see

“Coordination of Benefits” section.

DENTAL BENEFIT

This section includes the following:

- Benefit Description
- Filing a Claim
- Filing Deadline
- Choosing A Dentist
- Participating Dentist Program
- Using a non-Participating Dentist
- Pre-treatment plan
- Alternate Benefit Provision
- Non-covered dental services
- Dental Benefit Extension
- Coordination of Benefits
- Schedule of Dental Allowances

Benefit Description:

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

Maximum Benefit Per Person Each Plan Year (July 1 – June 30) is \$6,500.

Maximum Benefit Per Family Each Plan Year (July 1 – June 30) is \$13,000.

Maximum Benefit Per Person per lifetime for Orthodontic Coverage (for Dependent Children Only) is \$4,940.

All dental reimbursements are in accordance with the “Schedule of Dental Allowances”.

Filing a claim:

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

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

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

Filing deadline:

All dental claims must be postmarked no later than 1 Year after the date of service.

Choosing a Dentist:

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

Participating Dentist Program:

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

- For services listed in the Schedule for which the Fund will not pay due to Plan limitations and exclusions or where frequency limitations and plan maximums are exceeded.

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

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

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

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

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

Using a non-Participating Dentist:

If you choose to seek treatment from a non-participating dentist, the Fund will reimburse you up to the maximum allowance set forth in the “Schedule of Dental Allowances” in accordance with the Plan’s limitations and exclusions (see non-covered services in this

section). If the non-participating dentist charges less than the Schedule allows, you will be reimbursed for the actual amount of your bill. If your dentist charges more than the schedule allows, you will be reimbursed for the scheduled amount and you will be responsible for the balance of the charge yourself.

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

Pre-treatment plan:

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

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

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

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

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

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

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

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

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

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

Alternate Benefit Provision:

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

Non-covered dental services:

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

- Procedures performed by a patient's immediate family (mother, father, son, daughter, spouse, domestic partner, brother or sister) with the exception that coverage will be provided for fees for laboratory services related to fixed and removable prostheses, which would include full dentures, partial dentures, crowns, bridges, castings, inlays and bite plates;
- Procedures or supplies not listed in the dental schedule;
- Services and supplies not furnished by a dentist, except X-rays ordered by a dentist and the services of a licensed dental hygienist performed under a dentist's supervision;
- Services provided by the U.S. government or any other government, for which payment is not required of the member;
- Surgical and prosthetic aspects of implants except as noted in the "Schedule of Dental Allowances". Payment will be made only for conventional restoration of the mouth;
- Services resulting from an automobile accident covered by No-Fault insurance;
- Services caused by war or an act of war or while serving in the military;
- Cosmetic services unless made necessary because of an accident while the member is covered;
- Services resulting from a work-related accident or disease covered by Workers' Compensation;
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the temporomandibular joint;
- multiple bridge abutments.

Dental Benefit Extension:

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

Benefits are extended for:

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

For dental benefit extension beyond 30-days see “Continuation of Coverage (COBRA)”.

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have.

For a complete description see “Coordination of Benefits” section .

SCHEDULE OF DENTAL ALLOWANCES

Self-insured Dental Services / Administrative Services Only, Inc

Dental Plan Administrator

**DOCTORS COUNCIL WELFARE FUND \ DOCTORS COUNCIL RETIREE WELFARE FUND
SESSIONAL & PART-TIME MEMBERS – 50% OF Schedule**

<u>DIAGNOSTIC & PREVENTIVE</u>	Scheduled Allowance	<u>PERIODONTICS</u>	Scheduled Allowance
ORAL EXAM	60.00	PERIODONTAL TREATMENT	
FULL MOUTH SERIES	120.00	Root scaling, subgingival curettage, bite correction, including propl	
PANORAMIC X-RAY	120.00	Per visit	70.00
PA or BW X-RAY	12.00	Full mouth	80.00
OCCLUSAL FILM	50.00	OCCLUSAL ADJUSTMENT – COMPLETE	80.00
EXTRA ORAL or TMJ FILM	34.00	PERIODONTAL SURGERY	
CEPHALOMETRIC FILM	85.00	Gingivectomy or gingivoplasty, delivery of	
PROPHYLAXIS – ADULT	80.00	Chemotherapeutic agents, soft tissue graft	
PROPHYLAXIS – CHILD	40.00	Vestibuloplasty, any combination, per quad	150.00
SPACE MAINTAINER – ACRYLIC	101.00	OSSESIOUS SURGERY	525.00
SPACE MAINTAINER – METAL	250.00	OSSESIOUS GRAFT - SINGLE SITE	150.00
FLUROIDE	35.00	OSSESIOUS GRAFT – MAX PER JAW	450.00
SEALANT	35.00	GUIDED TISSUE REGENERATION	275.00
DIAGNOSTIC CASTS	30.00	FREE SOFT TISSUE GRAFTS – PER QUAD	450.00
<u>RESTORATIVE</u>		<u>ORAL SURGERY</u>	
SILVER AMALGAMS		ROUTINE EXTRACTION	100.00
One surface	90.00	SURGICAL EXTRACTION	
Two surface	120.00	Erupted tooth	200.00
Three surfaces	140.00	Impaction – soft tissue	200.00
Four or more surface	140.00	Impaction – partial bony	325.00
PLASTIC or SILICATE FILL	30.00	Impaction – complete bony	425.00
COMPOSITE RESIN - 1srf anterior	100.00	CYST REM OVAL	150.00
COMPOSITE RESIN - 2srf anterior	115.00	ALVEOLOPLASTY – per quad	120.00
COMPOSITE RESIN - 3 or more surfaces anterior	145.00	INCISION AND DRAINAGE	85.00
RESIN – INCISALANGLE	175.00		
COMPOSITE RESIN - 1srf posterior	110.00	<u>DENTURES</u>	
COMPOSITE RESIN - 2srf posterior	140.00	COMPLETE DENTURE	
COMPOSITE RESIN - 3srf posterior	160.00	Immediate or permanent	750.00
PIN RETENTION	25.00	PARTIAL ACRYLIC BASE	475.00
METALLIC INLAY - 1srf	150.00	UNILATERAL – one tooth	500.00
METALLIC INLAY - 2srf	400.00	PARTIAL – CAST METAL BASE	750.00
METALLIC INLAY - 3srf	500.00	TISSUE CONDITIONING	70.00
PORCELAIN INLAY - 1srf	168.00	PRECISION ATTACHMENT	325.00
PORCELAIN INLAY - 2srf	400.00	DENTURE REPAIRS	
PORCELAIN INLAY – 3srf	500.00	Broken denture base	95.00
COMPOSITE INLAY – 1srf	95.00	Replace tooth in denture	95.00
COMPOSITE INLAY – 2srf	125.00	Replace broken facing	95.00
COMPOSITE INLAY – 3srf	300.00	Add or replace clasp	125.00
CAST POST & CORE	300.00	Reattach clasp	65.00
PER-FAB POST & CORE	175.00	Add tooth to existing partial	125.00
LAMINATE VENEER - LAB	450.00	DENTURE ADJUSTMENT	40.00
		DENTURE RELINE	
<u>CROWNS & BRIDGES</u>		Partial – office	135.00
CROWNS		Complete – office	165.00
Acrylic jacket (lab)	193.00	Partial or complete – lab	300.00
Stainless steel (primary tth)	67.00	BRIDGE PONTICS	
Porcelain jacket	650.00	Full cast	500.00
Plastic with metal	425.00	Plastic with metal	425.00
Porcelain with metal	650.00	Porcelain with metal	550.00
Full cast	600.00	ENDOSSEOUS IMPLANT	1400.00
¾ cast	400.00	SUBPERIOSTEAL IMPLANT	1400.00
RECEMENTATION		CROWN OVER IMPLANT	900.00
Of crown or inlay	50.00	ABUTMENTS	
Of bridge	85.00	Inlay – 2 surface	400.00
		Inlay – 3 surface	500.00
<u>ENDODONTICS</u>		Plastic with metal	425.00
PULP DIRECT – direct	50.00	Porcelain with metal	650.00
PULP CAP – indirect	35.00	Full cast	375.00
VITAL PULPOTOMY	110.00	¾ cast	400.00
ROOT THERAPY		Maryland bridge retainer	250.00
One canal	450.00	Custom Abutment	500.00
Two canals	550.00		
Three canals	700.00	<u>ORTHODONTICS</u>	
Four canals	700.00	DIAGNOSIS & INTIAL INSERTION	1250.00
APICOECTOMY – 1 ST root	300.00	ACTIVE TX – per mouth	120.00
APICOECTOMY – maximum per tooth	600.00	POST-TREATMENT STABILIZATION DEVICE	225.00
RETROGRADE ROOT FILL – per root	125.00	PASSIVE TX – per 3 months	120.00
ROOT RESECTION	175.00		
ROOT THERAPY – RETREATMENT		<u>ADJUNCTIVE SERVICES</u>	
One canal	600.00	GENERAL ANESTHESIA/ IV SEDATION	200.00
Two canals	750.00	CONSULTATION	85.00
Three canals	825.00	PALLIATIVE TREATMENT	45.00
		ANALGESIA	25.00
		APPLICATION OF DESENSITIZING AGENT	20.00
		BRUXISM APPLIANCE	300.00

HEALTH CARE COST REIMBURSEMENT BENEFIT

This section includes:

- Benefit Description
- Covered Services
- Filing Procedure

Benefit Description:

Under this benefit, retiree, spouse or domestic partner are entitled to a \$1,000 health care reimbursement expense every plan year (July 1 - June 30).

Covered Services:

The following services are covered:

- 1) Medical and Hospital Deductibles and Co-Payments under Medicare and/or your group medical/surgical and hospital insurers;
- 2) Prescription Drug Deductibles or Co-Payments under your group medical/surgical and hospital insurers;
- 3) Charges incurred for health services covered in a member's existing coverage that exceed the reimbursement received, including services covered under Doctors Council Retiree Welfare Fund;
- 4) Premiums for Medicare Part "B", Medigap, and other out-of-pocket healthcare expense;

Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the claim form and attach all Explanation of Benefits Statements and Itemized Bills. **The Fund recommends that you submit your claim at the end of the Plan Year unless you have already met the full amount of the benefit (\$1,000). All claims for benefits for the Plan Year ending June 30 must be postmarked no later than June 30th of the following Plan Year (July 1 - June 30).**

HEARING AID BENEFIT

This section includes the following:

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

Benefit Description:

Under this benefit, a retiree and spouse or domestic partner 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 up to \$1,500 per person. *Hearing aids are available for both ears if prescribed.*

Covered Expenses:

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

Exclusions:

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

Claim Filing Procedure:

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

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

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description see the "Coordination of Benefit" section.

LEGAL SERVICES BENEFIT

New York State Residents

This section includes the following:

- Benefit Description
- Exclusions
- Filing Procedure

Benefit Description:

The legal services covered by the 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, 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 member'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 member is responsible for reimbursing the law firm directly for expenses (e.g., filing fees, photocopies, transportation, etc.) for services performed on behalf of the member or his/her spouse or domestic partner. No expense over \$75 will be incurred without the member's prior knowledge and approval. The law firm will require payment of an advance against disbursements for expenses and legal fees of up to \$10,000 for all matters where fees are not capped or part of the two (2) hours at no charge, as indicated below. Any unused portion of an advance retainer payment will be returned at the conclusion of representation. On matters where the fee is a fixed amount, as indicated below, full payment will be due at the initial consultation and before the commencement of work on such matter. Any member whose account is not paid in a timely manner will not be entitled to further representation under the Plan. References to member mean the covered person who is eligible for the Legal Service Benefit and through whom the benefits flow.

Legal services will be available at the fees indicated hereafter to covered members 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 member individually or jointly with another family relative and used as the member's primary residence is covered at a fee of \$575; 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 \$650 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 \$775 per transaction 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 \$575 for the first transaction and \$650 for the second transaction. In addition, an advance of \$150 shall be due for each transaction to cover anticipated expenses and any amount not utilized will be returned. If expenses exceed that amount, they will be separately billed.

MATRIMONIAL:

An uncontested divorce involving a covered member for a fixed fee of \$750, plus expenses. A divorce will not be considered "uncontested" if the parties require the negotiation or settlement of a separation agreement or the negotiation of alimony, child support or custody and will be covered under GENERAL CONSULTATION/ REPRESENTATION below (two (2) hours at no charge and then fifty (50) hours at reduced hourly rate of \$200).

ADOPTION:

An uncontested adoption, where a covered member is an adoptive parent for a fixed fee of \$750, plus expenses.

NAME CHANGE:

A change of name of a covered member, spouse/domestic partner or dependent for a fixed fee of \$750, plus expenses.

CRIMINAL DEFENSE: Defense in a criminal prosecution, up to and through the point of arraignment, for a covered member, spouse or domestic partner for a fixed fee of \$750, plus expenses.

GENERAL

CONSULTATION/

REPRESENTATION: In each Plan Year, a covered member will be entitled to two (2) hours of general consultation (without charge to the participant) or other legal services on behalf of a covered member, spouse or domestic partner concerning any legal matter or matters and up to fifty (50) additional hours at a reduced hourly rate of \$200 (payable by the covered member). The total two (2) hours at no charge and up to fifty (50) additional hours at the reduced hourly rate of \$200 is the maximum yearly benefit, whether incurred on a single matter or multiple matters. If a matter is ongoing (and continues into the next Plan Year) and additional hours have been billed, the two hours at no charge will reset and may be applied to hours incurred in the subsequent Plan Year. The fifty hours at \$200/hour will not reset or otherwise be extended after they have been used on such matter. Upon the exhaustion of these hours, the member may, at his or her option, retain the firm at its regular hourly rates, which will be discounted by 20%, or obtain other counsel. This section does not apply to matters covered under the Plan on a fixed fee basis or otherwise as provided below.

STATE LICENSE

PROCEEDINGS: Representation of a covered member in a proceeding initiated by a New York State administrative agency which may result in the suspension or revocation of the member's

license at a reduced hourly rate of \$200 (payable by the covered member) for up to fifty (50) hours (not including the initial two hours without charge if not already used during the Plan Year). If the State License Proceeding is ongoing (and continues into the next Plan Year) and additional hours have been billed, the two hours at no charge and fifty hours at \$200/hour will reset and may be applied to hours incurred in that matter in the subsequent Plan Year. This is separate and distinct from GENERAL CONSULTATION/ REPRESENTATION above.

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 member 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 \$200 (payable by the covered member or his or her estate).

ESTATE PLANNING:

Drafting and settlement of a will or codicil (and any amendment to a will), including power of attorney, living wills and health care proxies for a covered member, spouse or domestic partner at a single charge of \$450 to the member; an \$800 fee covers services for both the eligible member and spouse or domestic partner, provided that the estate planning and preparation and execution of the wills are undertaken concurrently. In the case of complex estate planning, documents other than the will or codicil, power of attorney and health care proxy, such as an insurance trust or other trust documents related to estate planning,

will be prepared for an additional charge of \$300 per document. If the Estate Planning includes a real estate transfer, the fee for preparation of the documents necessary to effect such transfer will be \$575, as noted under REAL ESTATE above for a real estate transaction under the Plan.

PERSONAL INJURY: Personal injury and property damage actions on behalf of a covered member 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, New York City Health + Hospitals, or the New York City Transit Authority, or any other employer covered under a Doctors Council contract, or otherwise arising out of 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 to practice;
- 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, subject to meeting the legal and ethical requirements of doing so. In the event a member has failed to pay any fees or expenses due within thirty (30) calendar days of billing, the member's entitlement to additional services under this Benefit will be suspended until the amount due has been paid in full. Any fee dispute will be subject to resolution by arbitration before the American Arbitration Association under its applicable rules, which shall be the exclusive means of settling any such dispute, except as otherwise required by New York law or regulation.

Filing Procedure:

You must call the Plan Office directly at (212) 532-7690. The Plan Office will then determine whether you are eligible and advise the law firm accordingly or send you the appropriate reimbursement forms if you participate in the Out-of-State Legal Services Plan (LSP). If you participate in the In-State LSP the Plan 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.

LEGAL SERVICE BENEFIT

Out-of-State Residents

This section includes the following:

- Benefit Description
- Filing Procedure
- Filing Deadline

Benefit Description:

Members who reside outside of the State of New York will be enrolled in the Out-of-State Legal Services Plan (LSP) unless they express their wishes in writing to join the In-State Legal Services Plan. In order to choose the In-State LSP, a member must notify the 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. The member will remain in the In-State LSP until further notice to the Plan Office in writing, prior to the commencement of any Plan Year, that the member wishes to return to the Out-of-State LSP. 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 the member or spouse/domestic partner OR a real estate closing (restricted to personal residence of the member or spouse/domestic partner) or the refinancing of a mortgage once each Plan Year. 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.

Filing Procedure:

You must call the Plan Office directly at (212) 532-7690. The Plan Office will then determine whether you are eligible and send you the appropriate reimbursement forms to participate in the Out-of-State LSP.

Filing Deadline:

Claims postmarked more than one (1) year (365 calendar days) after the date service is rendered will not be considered for payment.

MAMMOGRAPHY BENEFIT

This section includes the following:

- Benefit Description
- Filing Procedure
- Coordination of Benefit

Benefit Description:

Reimbursement of \$200 per Plan Year (July 1 – June 30) is available to retiree, spouse or domestic partner.

Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the claim form and attach a copy of your itemized receipt and return the claim form to the Fund Office postmarked within one (1) year from the date service was completed.

Claims postmarked more than one (1) year from the date service was completed will not be considered for payment.

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description see the “Coordination of Benefits” section.

OPTICAL BENEFIT

This section includes the following:

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

Benefit Description:

Retiree, spouse or domestic partner and eligible dependent children are each entitled to reimbursement once every Plan Year (July 1 – June 30) for prescription eyeglasses, contact lenses and eye examinations up to \$300 per person. In addition, Lasik surgery procedures will be reimbursed up to a lifetime maximum of \$500.

Exclusions:

Exclusions under this benefit are:

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

Filing Procedure:

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

Coordination of Benefits:

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

For a complete description see the "Coordination of Benefits" section.

PHYSICAL EXAMINATIONS

Benefit Description:

Retirees and spouses or domestic partners are covered for an annual physical examination as described below. The examinations will be provided by Affiliated Physicians. Their office is located at 18 East 48th Street in New York City.

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

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

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

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

The exam will include the following:

Complete Personal and Family History

Physical Examination Of All Body Systems

X-ray of the Heart and Lungs

12 Lead Resting Electrocardiogram with complete interpretation

Audiometric screening (500, 1000, 2000, 3000, 4000, 6000 CPS)

Eye Tests by Ortho-rater

Near and Distant Vision

Color Vision

Tonometry for Glaucoma Complete pulmonary function analysis

Pap Smear

Thyroid Function Test

PSA

Stool test for occult blood (3 slides)

SMAC blood chemistry analysis

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

Cholesterol Fractionation, for coronary risk evaluation:

HDL (High Density Lipoprotein)

LDL (Low Density Lipoprotein)

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

PODIATRY BENEFIT

This section includes:

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

Benefit Description:

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

Maximum allowance per plan year is \$5,000.00

Impression of the feet and construction of the Orthotic appliance maximum per Plan Year is \$450.

Filing Procedure:

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

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description see the “Coordination of Benefits” section.

SCHEDULE OF PODIATRIC ALLOWANCES

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

SCHEDULE OF PODIATRIC ALLOWANCES (cont'd)

Hallux valgus (bunion) correction, with or without Sesamoidectomy; simple exostectomy (silver type procedure)	1,912.50
Keller, McBride or Mayo type procedure with metatarsal osteotomy (Mitchell or Lapidus type procedure)	2,377.50 2,550.00
Hallux valgus (bunion) correction; by phalanx osteotomy	2,062.50
Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction, other than first metatarsal	1,402.50
Osteotomy for shortening, angular or rotational correction; proximal phalanx first toe (separate procedure)	1,200.00
Impression of feet, plaster foot casting and construction of orthotics	450.00
Cast clubfoot unilateral	150.00
Cast clubfoot bilateral	375.00
Splint short leg	202.50
Strapping ankle	52.50
Strapping toes	75.00
Strapping unna boot	112.50
Aspiration of ankle joint with steroid injection	142.50
Aspiration and injection of bursa	142.50
Drainage of subcutaneous hematoma	142.50
Excision of verruca	525.00

PRIVATE DUTY NURSING BENEFIT
(IN-HOSPITAL)

This section includes the following:

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

Benefit Description:

Under this benefit, retirees and spouses or domestic partners are eligible for reimbursement for private duty nursing costs, provided by a registered nurse or licensed practical nurse only, if you are hospitalized in an acute care hospital and your doctor orders the nursing. The benefit allowance is \$900 per 24-hour period per person to a maximum of \$5,400 per confinement per person.

Exclusions:

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

Filing Procedures:

To file a claim for this benefit, obtain a claim form from the Fund Office. Complete the member's portion and have your physician complete the physician's portion. Return the claim form to the Fund Office within 90 days after your hospital discharge date with copies of all receipts, insurance payments or other relevant insurance documents. **Claims postmarked more than one (1) year after your hospital discharge date will not be considered for payment.**

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description see the "Coordination of Benefits" section.

PSYCHIATRIC BENEFIT
(OUT-OF-HOSPITAL)

This section includes the following:

- Benefit Description
- Filing Procedure
- Coordination of Benefits

Benefit Description:

Under this benefit, retirees and spouses or domestic partners who receive out-patient psychiatric care by a board eligible or certified psychiatrist, a state-certified psychologist, licensed psychoanalyst, or state-certified psychiatric social worker (CSW) will be reimbursed 50% of the reasonable cost of each visit.

Maximum Benefit Per Person for Each Plan Year (July 1 - June 30) is 50 visits per person.

Filing Procedure:

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

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description see the "Coordination of Benefits" section.

SELF-PAID CONTINUATION OF COVERAGE
(COBRA)

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

This section includes the following:

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

Benefit Description:

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

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

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

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

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

COBRA Continuation Coverage:

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

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

ACQUIRING A NEW DEPENDENT DURING THE COBRA CONTINUATION COVERAGE PERIOD:

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

Loss of Other Group Health Plan Coverage:

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

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

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

INITIATING COBRA CONTINUATION COVERAGE:

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

- (1) The divorce or legal separation of a covered employee from his or her spouse.
- (2) A beneficiary ceasing to be covered under the Fund as a dependent child of a participant.
- (3) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum of 18 (or 29) months. This second Qualifying Event could include an employee's death, entitlement to Medicare, divorce or legal separation or a child losing dependent status.

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

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

- be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA Continuation Coverage.
- (5) When the Social Security Administration determines that a Qualified Beneficiary is no longer disabled.

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

How Should A Notice Be Provided?

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

When Should the Notice Be Sent?

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

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

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

Who can Provide a Notice?

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

Your employer should notify the Fund Office of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also notify the Fund Office promptly and in writing** if any such event

occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Fund Office.

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

Self-Paid Premium:

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

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

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

Termination of COBRA Continuation Coverage:

COBRA Continuation Coverage will terminate on the earliest of:

- Failure to pay the required premium on time;
- The date the individual becomes covered under another Employer-funded group health Plan either as an employee or dependent unless the individual has a pre-

existing condition which the other Plan will not cover. In that event the individual (and eligible dependents) may be allowed to continue his or her COBRA Continuation Coverage for the applicable maximum period or wait until the other Plan's pre-existing condition exclusion no longer applies to that individual. Contact the Fund Office for details.

- The date the individual becomes enrolled in Medicare (except in the case of a Medicare-entitled spouse of a deceased member). However, the individual's non-Medicare-entitled dependents can continue coverage for up to 36 months from the date of the individual's Medicare entitlement.
- The date the group health Plan terminates as to the eligible group of which you were a member. If the coverage is replaced, your coverage will be continued under the new Plan.
- 18 months (maximum) from the Qualifying Event if coverage is being continued for an employee, spouse or dependent because the employee ceased covered employment or lost eligibility due to reduced hours. This may be extended to 29 months (maximum) in the case of a determination of disability by the Social Security Administration. See "Entitlement to Social Security Disability Income Benefits" section.
- 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or dependent for a reason other than the employee's loss or reduction of employment, including the participant's Medicare entitlement.
- Full details of COBRA Continuation Coverage will be furnished to you or your dependents when the Fund Office receives notice that one of the Qualifying Events has occurred. **Therefore, we urge employees and dependents to contact the Fund Office as soon as possible after one of those events.**

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

Entitlement to Social Security Disability Income Benefits:

If you, your spouse or any of your covered dependents are entitled to COBRA Continuation Coverage for an 18-month period, that period can be extended for a covered

person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if:

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

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

Second Qualifying Events:

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

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

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

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

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

Confirmation of Coverage:

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

KEEP THE FUND INFORMED OF ADDRESS CHANGES:

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

CERTIFICATE OF CREDITABLE COVERAGE

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

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

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

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

OTHER IMPORTANT INFORMATION

This section includes:

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

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

Claims and Appeals Procedures

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

How to File a Claim:

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

Simple inquiries about the Fund's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Fund is not a claim for benefits. A claim form may be obtained from the Fund Office by calling (212) 532-7690.

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

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

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

When Claims Must Be Filed:

Claims must be postmarked no later than one (1) year from the date services were received, with the following exceptions:

- Physical Examination Benefit and In-state Legal Services Benefit require that you call the Fund Office first to verify eligibility, before making an appointment with Affiliated Physicians or Pryor Cashman, LLP. You do not need to file a claim for the Physical Examination Benefit or the In-state Legal Service Benefit.
- Healthcare Cost Reimbursement Benefit claims must be postmarked by September 30 in the year following the end of the Fund Year (June 30)

WHERE TO FILE CLAIMS:

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

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

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

For Dental Benefits, please mail claims to:

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

Authorized Representatives:

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

CLAIMS FOR BENEFITS:

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

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

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

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

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any

further bills or statements for covered services to the Fund or SIDS as soon as you receive them.

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

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

NOTICE OF DECISION:

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

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

receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

REQUEST FOR REVIEW OF DENIED CLAIM:

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

REVIEW PROCESS:

The review process works as follows:

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

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

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

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who did not take part in the adverse benefit

determination (and is not subordinate to any individual who did) and who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal:

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

Notice of Decision on Review:

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

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

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

Limitation on When a Lawsuit May Be Started:

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final

decision. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

Members' Rights:

Participants may:

- Examine all Fund documents without charge at the Fund Office. These include minutes of Trustees meetings, detailed annual reports and other documents, if any, defining the benefits available to members
- Obtain copies of all Fund documents and other Fund information if copies are requested in writing. There may be a small charge to cover the cost of reproducing the documents
- Receive a summary of the Fund's annual financial report. The Fund Administrator will furnish to all members a copy of this summary annual report

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

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

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

Plan Amendments or Termination:

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

Discretionary Authority of the Plan Administrator and its Designees:

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

No Liability For the Practice of Medicine:

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

Additional Information:

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

Fund Sponsor:

Doctors Council Retiree Welfare Fund

EIN Number Assigned by the

Internal Revenue Service:	13-3324980
Fund Administrator:	Board of Trustees of the Doctors Council Retiree Welfare Fund
Agent for Service of Legal Process:	Fund Administrator
Official Name of the Plan:	Doctors Council Retiree Welfare Fund
Type of Plan:	Welfare Fund
Type of Administration:	Self-Insured
Plan Year:	July 1 - June 30

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