

DOCTORS COUNCIL BENEFIT PLAN B

BENEFIT BOOKLET

DOCTORS COUNCIL BENEFIT PLAN - PLAN B

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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 B. **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. The Plan Trustees reserve the right to change benefits as the need arises. Of course, it is important that you read all communications sent to you by the Plan Office.

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 Plan Office will be pleased to help you.

Sincerely,

Board of Trustees

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INTRODUCTION

Benefits described in this booklet are for employees of Correctional Dental Associates (CDA). at Correctional Health Services (CHS), New York University (NYU) at Coler\ Henry J. Carter (HJC), New York University (NYU) at Woodhull-Cumberland, Physician Affiliate Group of New York, P.C. (PAGNY) at Coney Island Hospital, PAGNY at Correctional Health Services, PAGNY at Harlem Hospital, PAGNY at Jacobi\ NCB Hospital, PAGNY at Kings County Hospital, PAGNY at Lincoln Hospital and PAGNY at Metropolitan Hospital.

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

- 1) **File your benefit claims on time.** The Doctors Council Benefit Plan B must receive the required documents postmarked no later than **one year (365 days)** from the date of service unless expressly indicated otherwise for a particular benefit. If you believe that your claim will be late, contact the Plan Office in writing **before the 365th day** after the date of service for further instructions;
- 2) Notify the Plan Office at once if there is a change in your family status;
- 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 Plan Office and respond to all requests in a timely fashion.

MEMBER ELIGIBILITY

Eligibility Requirements:

You are eligible for the benefits described in this booklet if you are employed by:

- (a) Correctional Dental Associates (CDA), at Correctional Health Services or New York University (NYU) at Woodhull-Cumberland or Physician Affiliate Group of New York, P.C. (PAGNY) at Kings County Hospital or Lincoln Hospital or PAGNY at Jacobi\ NCB Hospital for **21** hours or more per week on a regular basis, or PAGNY at Correctional Health Services or

- (b) New York University (NYU) at Coler/Henry J. Carter (HJC) Hospital or Physician Affiliate Group of New York, P.C. (PAGNY) at Metropolitan Hospital for **17 1/2** hours or more per week on a regular basis or

- (c) Physician Affiliate Group of New York, P.C. (PAGNY) at Coney Island Hospital:
 - Doctors employed 20 hours or more per week as of 9/1/10
 - Doctors **hired after** August 31, 2010 and employed **21** hours/ week or more; doctors **hired after** August 31, 2010 and **working less** than **21** hours/week are not covered under any Benefit Plan or

- (d) Physician Affiliate Group of New York, P.C. (PAGNY) at Harlem Hospital:
 - Doctors employed by PAGNY as of January 1, 2011 and work **20** or more hours per week, **or**
 - Doctors employed by PAGNY **after** January 1, 2011 and work a minimum of **21** hours per week

The employers listed above are hereinafter collectively referred to as the "Employer". The number of hours indicated above are required in order to be eligible for benefits and are hereinafter referred to as "full time".

TERMINATION OF COVERAGE

Coverage ends when you leave employment with the Employer or are employed less than full-time, provided however, that dependent coverage continues for 30 days after the death of the member.

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

FAMILY/MEDICAL/MILITARY LEAVE

This section includes the following:

- Family and Medical Leave
- Military Leave

Family and Medical Leave:

If you are entitled by law to up to 12 weeks of unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill, or for your own serious illness, you can continue your medical coverage during that leave period. Your Employer is required to continue to pay it's own contributions for that coverage during the period of that leave. If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation Coverage. Please turn to the section of this booklet entitled "Self-Paid Continuation of Coverage (COBRA)" for details on how you can continue coverage for yourself and/or your dependents.

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

Military Leave:

In addition to the rights you have to continue coverage under "COBRA," as further described later in this document, you also have continuation coverage rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended. USERRA provides that if you go into active military service for up to 31 days, you can continue your medical coverage during such leave period. Your Employer must continue to pay your contributions for coverage during such period of leave. If you are called into active military

service for more than 31 days, you may be able to continue your coverage at your own expense for up to 24 months.

If you lose eligibility because of your induction into the Armed Forces, you will be reinstated for benefits as of the date of your re-employment with a contributing Employer, provided that you secure such employment within one year of your discharge from the service or within one year of recovery if you are hospitalized for, or convalescing from, an illness or injury at the time of your separation from the service.

Questions regarding your entitlement to this leave should be referred to your Employer. Questions about the continuation of your coverage under the Plan should be referred to the Plan Office.

BENEFIT COST

While you are eligible to be a Plan member, the benefits described in this booklet are provided without cost to you as the primary beneficiary. *The Employer pays the entire cost through contributions under the Doctors Council collective bargaining agreement.* The contributions for these benefits do not come from payroll deductions. When you or your dependents cease to be eligible for benefits, you or they must contact the Plan Office for information about continuation of benefits on a self-paid basis. Please turn to the section of this booklet entitled “Self-Paid Continuation of Coverage (COBRA)” for details on how you can continue coverage for yourself and/or your dependents.

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:

For family coverage to be in effect you must properly enroll your Eligible Dependents. An "Eligible Dependent" is any one of the following persons:

- Your legal spouse or "domestic partner" (as defined below); or
- Your unmarried child(ren) or grandchild(ren) who fall into at least one of the following categories:
 - Under age 19 (and will not reach age 19 by the end of the year); has the same principal place of abode as you for more than one-half of the year; and does not provide over one-half of his or her own support.
 - Over age 19 and up to age of 26 under the Affordable Care Act with the completion of the Special Enrollment Form.
 - Age 19 or older; is permanently and totally disabled due to a physical or mental disability or condition that began prior to age 19 and that prevents the child from engaging in any self-sustaining employment; has the same principal place of abode as you for more than one-half of the year; and does not provide over one-half of his or her own support.

The Plan may require proof of dependent status at any time. Proof of dependent status includes tax returns, adoption or custody forms, certification of full-time student status, marriage or birth certificate, or other proof.

A domestic partner is defined as a person, eighteen years of age or older, who is not married or related by blood to you in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with you and has been living with you on a continuous basis, and who, together with you, has registered with the City of New York as a

domestic partner and has not terminated the domestic partnership. Members who are not eligible to register with the City of New York as a domestic partner because of their residency may satisfy the registration requirement by providing an Affidavit of Domestic Partnership, which must include a statement as to why they are not eligible to register with the City of New York. **In order to qualify for benefits, you must submit a copy of your registration certificate indicating the exact date you first registered or the Affidavit of Domestic Partnership.** Unless you provide over half of your domestic partner's support and your domestic partner lives with you the Internal Revenue Service currently treats as imputed income to you the value of the benefits coverage provided you your domestic partner. You are advised to review the consequences of electing this benefit with your own tax advisor. Furthermore, please note that, generally speaking, if an individual who is covered as your dependent under the Plan does not meet the definition of "qualifying child" or "qualifying relative" under Section 152 of the Internal Revenue Code (other than the income requirements of the "qualifying relative" definition), the Internal Revenue Service also treats the value of benefits coverage provided to such an individual as imputed income to you. Thus, you are also advised to consult with your own tax advisor if you have any questions regarding whether covering a particular individual will result in taxable income to you.

In cases of multiple marriages/domestic partnerships when determining annual or lifetime maximums, the Doctors Council Benefit Plan 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 Plan Administrator or its designee will determine if the court or state administrative agency order is a Qualified Medical Child Support Order (QMCSO) as defined by federal law, and that determination will be binding on the member. If the order is issued by a state administrative agency, the order must be issued

through an administrative process established by state law and must have the force and effect of state law under the applicable state law.

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

If an order is determined to be a QMCSO, and if the member is covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan'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 Plan's requirements for coverage of that dependent child have been satisfied.

Plan members and their beneficiaries can obtain, without charge, a copy of the Plan's procedures governing QMCSO determinations from the Plan Office.

Extension of Dependent Coverage:

Dependent coverage continues for 30 days without cost only after the death of the member. For coverage beyond 30 days after the death of the member and for coverage after divorce, or after legal separation, or when a dependent no longer qualifies as such, see the section of this booklet entitled "Self-Paid Continuation of Coverage (COBRA)".

Changes in family status or family circumstance:

- The Plan Office should be notified promptly when any change occurs in your family status such as: marriage, divorce, separation, termination/initiation of domestic partnership, birth or adoption of a child, death of the member, death of an eligible

dependent or you wish to change the beneficiary of your life insurance benefit. The Plan Office must be notified within 30 days of the change.

- The member or eligible dependents should notify the Plan Office 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.
- The Plan Office should also be notified promptly of any change in employment status or leave of absence which may entitle you to continuation of coverage.

COORDINATION OF BENEFITS

This section includes the following:

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

Definition of Coordination of Benefits:

The Doctors Council Benefit Plan B 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. You may be covered as a dependent under your spouse's plan in addition to being covered under this Plan, or your dependents may be covered under both plans. 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.

Determination of Benefit Payments:

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

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

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

Medicare:

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

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

Medicare and End-Stage Renal Disease:

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

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

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

primary coverage for a total time period of 33 months. Beginning with the **34th month**, Medicare will pay first and this Plan will pay second.

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

CLAIM FILING PROCEDURES

This section includes the following:

- Claim Filing Procedure
- Claim Review

Claim Filing Procedure:

The procedure for filing claims depends on the benefit. Please see the explanation following each benefit for the correct procedure to follow. 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 Plan Office **before** the one (1) year deadline for further instructions. **Claims submitted to the Plan 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.

BLOOD BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefit

Benefit Description:

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

Claim Filing Procedure:

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

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

Claims submitted to the Plan postmarked more than one year (365 days) from the date of your hospital discharge will not be considered for payment.

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

DENTAL BENEFIT

This section includes the following:

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

Benefit Description:

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

Maximum Benefit Per **Person** Each Plan Year (January 1- December 31) is \$4,000.

Maximum Benefit Per **Family** Each Plan Year (January 1- December 31) is \$8,000.

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

All dental reimbursement is in accordance with the section entitled “Plan Description and Fee Schedule”.

Filing a claim:

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

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

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

Filing Deadline:

All dental claims must be postmarked no later than one year (365 days) from the date service was rendered.

Choosing a Dentist:

Treatment may be provided by a dentist in the Doctors Council Benefit Plan 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 this booklet in the section entitled “Plan Description & Fee Schedule” **with the following exceptions:**

- For services listed in the Schedule for which the Plan 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 dental services” in this section. However, if a dental service is performed for a condition that is not listed in the Schedule, but alternative treatments for that condition are listed, this Plan may pay a benefit based on the listed service that would produce a professionally satisfactory result.

Since usual and customary charges generally exceed the amounts listed in the Plan Description and Fee Schedule, using a participating dentist for treatment should represent an overall savings to you in the cost of your dental services.

It is important to understand that the Plan 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 Plan Office, and call for an appointment. Be sure to identify yourself as a member of the Doctors Council Benefit Plan 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 Benefit Plan.

Using a non-Participating Dentist:

If you choose to seek treatment from a non-participating dentist, the Plan will reimburse you up to the maximum allowance set forth in the Schedule of Dental Allowances which begins on page 23, in accordance with the Plan’s limitations and exclusions (see “Non-covered dental 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 Benefit Plan does not assign benefits — that is, payment is made to the member only.

Pre-treatment Plan:

The Plan recommends that you submit a pre-treatment estimate to the Plan'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 Plan 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 Plan 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 Plan for benefits (except where there is an Extension of Benefits as described above) and no significant change can have occurred in the condition of your mouth after the pre-estimate was issued and prior to the work. 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, THE PLAN RECOMMENDS THAT YOU SUBMIT A PRE-TREATMENT ESTIMATE PRIOR TO THE COMMENCEMENT OF THE WORK.

If a pre-treatment estimate is not submitted, the Plan's Dental Administrator will determine what benefits, if any, are payable. The Dental Administrator will take into consideration alternative courses of treatment, and if the benefit determined by the Dental Administrator is less than your total bill, you will be responsible for the difference.

Alternate Benefit Provision:

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could provide a suitable result based on common dental standards. In these instances, the Plan 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
- Orthodontia for member, spouse or domestic partner;
- 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.

Implantology:

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

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

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

Dental Benefit Extension:

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

Benefits are extended for:

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

For dental benefit extension beyond 30-days see COBRA Continuation Coverage see the section of this booklet entitled “Self-Paid Continuation of Coverage (COBRA)”.

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan’s coordination of benefit provisions, please see the discussion above.

**DOCTORS COUNCIL BENEFIT PLAN
PPO NETWORK
PLAN DESCRIPTION & FEE SCHEDULE**

This document is a brief description of the program. In cases of discrepancy the dental program document will control.

ELIGIBILITY	<ul style="list-style-type: none"> Covered Members are eligible for 100% of the Schedule of Allowances. Eligible dependents: Includes the lawful spouse and each dependent child from birth until the age of 26 is reached so long as they are not covered by or eligible for other health insurance through their employer and have completed an "Age 26 Young Adult Dependent Coverage Enrollment Form".
PLAN YEAR	<ul style="list-style-type: none"> January 1 st – December 31 st
PLAN MAXIMUM	<ul style="list-style-type: none"> \$4,000 per individual, \$8,000 family maximum in a calendar year
PLAN LIMITATIONS	<ul style="list-style-type: none"> Examination – Three in a calendar year Prophylaxis – Three in a calendar year X-rays – panoramic or full mouth series – \$140 per calendar year, any combination Replacement of crowns, bridges and dentures – not more than once in 4 years Palliative treatment – no other treatment rendered that same visit Fluoride treatment – to age 16, two per year Sealant – unrestored, permanent posterior teeth to age 19, lifetime maximum – 2 applications Root Scaling, curettage, bite correction; any combination, including prophylaxis – maximum \$300 in a calendar year Orthodontic treatment – Lifetime maximum of \$4,940. Orthodontic treatment is subject to the annual maximum. Participating Orthodontists will charge the Schedule of Allowances to the member when benefits have been exhausted, not to exceed 24 months of active treatment. Implants and Implant Restorations– \$5,000 per lifetime
PRE-TREATMENT REVIEW	<ul style="list-style-type: none"> This process is recommended for your benefit as it will give the dentist and plan member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. Please note- a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible Pre-op periapical x-rays required for crowns, veneers, inlays and extractions Periodontal charting and x-rays are required for surgical periodontal procedures Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework
PERMISSIBLE CHARGES	<ul style="list-style-type: none"> Covered and reimbursable services: None Covered but not reimbursable services: Schedule allowance Non-covered services: Your usual charge for that service
COORDINATION OF BENEFITS	<ul style="list-style-type: none"> If the patient is eligible for benefits under more than one group dental plan, you are entitled to collect benefits available through both plans. The total may not exceed your usual charge and payments from the other plan must first be applied to reduce or eliminate co-payments or charges levied due to maximums.
HOW TO FILE A CLAIM	<ul style="list-style-type: none"> As a Participating provider: Complete all necessary paper work and accept assignment of benefits. Claims must be filed within one year from the date of service. Complete a Claim Form (computer generated, ADA, and universal claim forms are accepted) and provide an itemized bill of services rendered. Signature on file is accepted. Enclose, when appropriate, x-rays, tooth charting, periodontal charting Mail claims to : Self-Insured Dental Services, Dept 82. P.O. Box 9005 Lynbrook, NY 11563

For up to date detailed information, including member eligibility, please access our website at:

www.asonet.com

If you have any questions regarding the operation of this program please contact S.I.D.S. at:
(516) 396-5500 or (718) 204-7172

Rev 6/11

DISABILITY BENEFIT

This section includes the following:

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

Benefit Description:

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

You are eligible for a gross monthly disability benefit of \$1,500.00, subject to applicable withholding taxes for the first six months of benefits. This amount is in addition to disability benefits you may be eligible for through Social Security or private insurance.

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

Payment Period:

Benefits under this Plan begin the first day following a ten-week waiting period (after you have been **TOTALLY DISABLED** for ten (10) consecutive weeks). **You do not receive benefits for the ten-week waiting period.** Successive disability periods separated by less than ten (10) weeks of continuous active employment in your profession are considered one continuous period of disability unless they arise from different and unrelated causes.

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

Exclusions:

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

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

Claim Filing Procedure:

Initial Application:

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

Follow-Up Report:

If, after having received our initial benefit payment from the 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 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. IF YOUR CLAIM IS APPROVED, THE PLAN RESERVES THE RIGHT TO OBTAIN SUBSEQUENT INDEPENDENT MEDICAL EXAMINATIONS AND TEST RESULTS TO VERIFY THE CONTINUING NATURE OF THE DISABILITY.

HEALTHCARE COST REIMBURSEMENT BENEFIT

This section includes:

- Benefit Description
- Covered Services
- Filing Procedure

Benefit Description:

Members, spouses or domestic partners and eligible dependent children are entitled to healthcare cost reimbursements every Plan year (January 1 – December 31) up to a maximum of **\$1,000** per family effective January 1, 2011.

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 and 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 Benefit Plan;
- 4) Premiums for Medicare Part "B", Medigap, and other out-of-pocket healthcare expenses.

Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Plan Office. Complete the claim form and attach all Explanation of Benefit Statements and itemized bills. **Do not submit your claim until the end of the Plan Year unless you have already met the full amount of the benefit. All claims for benefits for a Plan Year (ending December 31) must be postmarked no later than December 31st of the following year.** Only one claim per participant per Plan Year should be submitted for the Plan to process.

HEARING AID BENEFIT

This section includes the following:

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

Benefit Description:

Under this benefit, members and spouses or domestic partners 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.

Member or Spouse or Domestic Partner, per person.....\$1,500.00

Please note that these benefit amounts are based on services per ear every two (2) years and have been extended to include eligible dependent children.

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, Otolaryngologist or a licensed Audiologist
- cost of a hearing examination by an Otologist or Otolaryngologist physician or a licensed Audiologist if it is given with the intent or purpose of prescribing a hearing aid.

Exclusions:

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

Filing Procedure:

Obtain a claim form from the 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 for the hearing aid to this form, and return it to the Plan Office postmarked within one year from the date the services were rendered. **Claims postmarked more than one year from the date the services were rendered will not be considered for payment.** The bill must be itemized and describe the appliance purchased, the amount charged, the name of the person who required the hearing appliance, and the Otologist's or Otolaryngologist's authorization or certification.

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

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

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
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Benefits are available to members, spouses and domestic partners each Plan Year (January 1 – December 31) at the following level:

\$200.00

Claim Filing Procedure:

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

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

MATERNITY/ADOPTION BENEFIT

This section includes the following:

- Benefit Description
- Claim Filing Procedure

Benefit Description:

The benefit available to members, spouses or domestic partners for a live birth or adoption of a member's child is \$2,000 per claim. Member's name must appear on birth/adoption certificate.

Limited to one claim per Plan Year (January 1 – December 31).

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

Claim Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Plan Office. Complete the form and return it to the Plan Office with a copy of the birth/adoption certificate. **Claims submitted to the Benefit Plan postmarked more than one year after delivery/date on the adoption certificate will not be considered for payment.**

OPTICAL BENEFIT

This section includes the following:

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

Benefit Description:

Members, spouses or domestic partners and eligible dependent children are each entitled to **either** (a) reimbursement once every Plan Year (January 1 – December 31) for prescription eyeglasses, contact lenses and eye examinations to a maximum of \$300 per person **or** (b) obtain services from the PPO network of optical providers through CPS Optical; you can elect **only one form of benefit** each Plan year.

Optical PPO Network Through CPS Optical

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

Exclusions:

Exclusions under this benefit are:

- Expenses for which benefits are payable under any Workers' Compensation Law,
- Expenses for which benefits are payable under Medicare or any governmental plan,
- Medical or surgical treatment of the eye or eyes,
- Charges for services or supplies which are covered in whole under any other Plan,
- Charges for services provided by an immediate family member except for out-of-pocket expenses relating to materials and laboratory expenses at cost,

- Services provided by an individual who is not a licensed dispenser of these services.

Claim Filing Procedure:

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

Coordination of Benefits:

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

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

PHYSICAL EXAMINATIONS

Benefit Description:

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

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

A \$100.00 no-show fee is assessable to the member if an appointment is not canceled at least 48 hours prior to the confirmed time.

If an appointment is scheduled at an out-of-town facility, there will be a \$235.00 co-payment for the basic exam which the patient is responsible to pay at the time of the appointment.

The exam will include all of the following:

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

Thyroid Function Test

Pap smear

PSA

Complete pulmonary function analysis

Stool test for occult blood (3 slides)

SMAC blood chemistry analysis

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

Cholesterol Fractionation, for coronary risk evaluation:

HDL (High Density Lipoprotein)

LDL (Low Density Lipoprotein)

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

PODIATRY BENEFIT

This section includes the following:

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

Benefit Description:

Under this benefit members and spouses or domestic partners are reimbursed for visits to a podiatrist, up to a maximum of 15 visits per individual per Plan Year (January 1- December 31), according to the schedule of allowances listed below.

Maximum Allowance per Plan Year = \$5,000.00

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

Claim Filing Procedure:

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

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

SCHEDULE OF PODIATRIC ALLOWANCES

Office, new patient, intermediate service.....	\$105.00
Office established patient, intermediate service.....	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
Hellux valgus (bunion) correction, with or without Sesamoidectomy; simple exostectomy (silver type procedure).....	1,912.50
Keller, McBride or Mayo type procedure.....	2,377.50

with metatarsal osteotomy (Mitchell or Lapidus type procedure).....	2,250.00
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 orthotics and 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
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

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

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

Exclusions:

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

Claim Filing Procedure:

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

Coordination of Benefits

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

PSYCHIATRIC BENEFIT
(OUT-OF-HOSPITAL)

This section includes the following:

- Benefit Description
- Claim Filing Procedure
- Coordination of Benefits

Benefit Description:

Under this benefit, members, spouses or domestic partners and eligible dependent children who receive out-patient psychiatric care by a Psychiatrist, a Psychologist, or a Licensed Clinical Social Worker or equivalent in a state other than New York or Licensed Psychoanalyst, will be reimbursed for 50% of the reasonable cost of each visit (not to exceed \$56.00 per visit).

MAXIMUM BENEFITS PER FAMILY EACH PLAN YEAR (January 1–December 31):

70 visits per family

LIFETIME MAXIMUM

220 visits per family

Claim Filing Procedure:

Before you obtain treatment, obtain a claim form and complete the member's portion. Take the claim form with you to your appointment. Have the provider complete his/her portion of the claim form. Return the claim form with a copy of your bill and the Explanation of Benefit Statements from your other carriers within one year from the date service was rendered. If you have not received Explanation of Benefit Statements from your other carriers within the one-year period, you must submit to the Benefit Plan at the time you submit your claim proof that you filed your claim with other carriers within one year from date service was rendered. **Claims submitted postmarked more than one year from the date service was rendered will not be considered for payment.**

Coordination of Benefits:

Please remember that the benefit is coordinated with any other coverage you may have. For a complete description of the Plan's coordination of benefit provisions, please see the discussion above.

SELF-PAID CONTINUATION OF COVERAGE
(COBRA)

In compliance with a federal law commonly known as COBRA, this Plan offers its eligible 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” or simply “COBRA.”

This section includes the following:

- Benefit Description
- Initiating COBRA Continuation Coverage
- COBRA Continuation Coverage
- Self-Paid Premium
- Extension of COBRA Continuation Coverage
- Adding New Dependents and Loss of Other Group Coverage while Enrolled in COBRA
- Termination of COBRA Continuation Coverage
- Other COBRA Issues

Benefit Description:

Members and their eligible dependents have the right in many cases to continue to receive health benefits provided by the Plan on a self-paid basis if they fail to continue to qualify for Employer-provided benefits. Under the law, Members and their eligible dependents who are covered by the Plan 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 Plan 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. COBRA 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's termination of employment (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 (or the termination of a domestic partner relationship)	N/A	36 months	36 months
Dependent child ceases to have dependent status	N/A	N/A	36 months

*** This 18 month period may be extended to 29 months in the case of certain disability. See the section entitled, “Entitlement To Social Security Disability Income Benefits” for details.**

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 coverage for the life of the retiree. The retiree's spouse and dependent children are entitled to COBRA for the life of the retiree until the earlier of their death or the date that is 36 months after the retiree's death. The specifics of this coverage will be addressed if the situation ever arises. Contact the Plan Administrator if you have questions on this issue.

Medicare entitlement is not a qualifying event under this Plan, as Members do not lose coverage under the Plan due to their becoming entitled to Medicare.

Initiating COBRA Continuation Coverage:

As a covered employee or qualified beneficiary, you are responsible for providing the Plan Administrator with timely notice of certain qualifying events. You must provide them with notice of the following qualifying events:

- (1) The divorce or legal separation of a covered employee from his or her spouse (or the termination of a domestic partner relationship).
- (2) A beneficiary ceasing to be eligible to be covered under the Plan as a dependent child of a Participant.
- (3) The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA and during the first 18 months of COBRA Continuation Coverage. This second qualifying event could include an employee's death, divorce or legal separation (or the termination of a domestic partner relationship) or 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 Plan Administrator 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, the qualified beneficiary may be eligible for an 11-month extension of the 18 month coverage period, for a total of 29 months of COBRA.
- (5) When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Plan Administrator 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 must send a letter to the Plan Administrator containing the following information: your name, the event listed above of which you are providing notice, the date of the event, the date on which the Member and/or beneficiary will lose coverage, and any supporting documentation (*e.g.*, divorce decree, birth certificate, death certificate, or SSA determination).

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 later of (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event or (2) the date of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent within **60 days** of the later of the date of the SSA Disability Determination but 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. These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a summary plan description or a general (initial) notice by the Plan.

The 60 or 30 day time period to provide the required notice will not begin until you have been informed of the responsibility to provide the notice and the Plan's notice procedures through the furnishing of this summary plan description or a general (initial) notice by the Plan.

If notice is not received by the Plan by the end of the applicable period described in this section, you and/or your spouse and/or dependent will not be entitled to elect COBRA Continuation Coverage.

Who Can Provide A Notice?

Notice may be provided by the covered employee, a 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, his spouse and 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 Plan Administrator of an employee's death, termination of employment or reduction in hours. However, **you or your family should also notify the Plan Administrator 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 Plan Administrator.

Once you or your Employer have/has notified the Plan Administrator, the Plan will send you information about COBRA Continuation Coverage.

When the Plan Administrator has been provided notice of an initial qualifying event, a second qualifying event or a request for an extension on account of disability, but the request for COBRA or additional COBRA Continuation Coverage is denied, the Plan Administrator will send the involved individual a written notice stating the reason why the individual is not entitled to the requested COBRA Continuation Coverage. This notice will be provided within 14 days of receipt of notice of the qualifying event.

How To Elect COBRA Continuation Coverage:

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or the Plan Administrator 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 coverages. You and/or your dependents will then have 60 days from the date of notification, or, if later, the date that coverage is lost to apply for COBRA Continuation Coverage. If you and/or your dependents do not apply within that time, health care coverage will not be continued under COBRA (with the exception that coverage is extended for 30 days in the event of the Member's death).

COBRA Continuation Coverage:

If you elect COBRA Continuation Coverage, the Plan will provide you with coverage that is identical to the coverage you had under the Plan when the qualifying event occurred, but you must pay for it. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA Continuation Coverage. For example, both the employee and the employee's spouse may elect COBRA, or only one of them may choose to do so. A parent or legal guardian may elect COBRA for a minor child. If COBRA Continuation Coverage is elected, the Plan 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 and their eligible dependents. If there is a change in health coverage provided by the Plan to similarly situated active employees and their families, that change will be made in your COBRA Continuation Coverage. Legal, life insurance and disability benefits are not available to COBRA participants.

Self-Paid Premium:

The Plan will set premium payments according to federal law, which provides that the self-paid premium required by the Plan may cover the full cost to the Plan for the benefits plus a 2% administrative fee for a total of 102 percent (in the case of an extension of COBRA Continuation

Coverage due to a disability, 150 percent). If the cost changes, the Plan will revise and notify you in advance of the adjusted 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 was elected. After you make your first payment for COBRA, you will be required to pay for COBRA for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA are due by the first day of the calendar month for which coverage is to be provided. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

There is a grace period of 30 days to pay any periodic payment. **HOWEVER, IF THE PLAN DOES NOT RECEIVE PAYMENT BY THE END OF THE GRACE PERIOD, COBRA CONTINUATION COVERAGE WILL TERMINATE AS OF THE FIRST DAY OF THE APPLICABLE COVERAGE PERIOD.**

Extension of COBRA Continuation Coverage:

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 period; and
- you or the disabled person provide notice and a copy of such determination to the Plan Administrator within the 60 day period described above under the section entitled "When

Should the Notice Be Sent?", but no later than before the end of the first 18-month period.

This extended period of COBRA Continuation Coverage will end at the **earlier** of the end of 29 months from the date the qualified beneficiary would have lost coverage under the Plan or the date the individual is no longer entitled to Social Security disability benefits. A copy of any Social Security notice terminating the disability benefits must be forwarded to the Plan Administrator within 30 days of the notification.

Second Qualifying Event During an 18-Month COBRA Continuation Period

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 (or your domestic partnership ends), or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months. These events can be a second qualifying event only if they would have caused the qualifying beneficiary to lose coverage under the Plan if the first qualifying event had not occurred, and only if the notice described above under the section entitled "When Should the Notice Be Sent?" is provided in a timely fashion, with supporting documentation if necessary.

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.

Medicare Entitlement is not a qualifying event under this Plan as Members do not lose coverage under the Plan due to their becoming entitled to Medicare. As a result, Medicare entitlement following a termination of employment or a reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries. However, when the

qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

In no case is the 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 above). 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 may not be extended beyond 18 months from the initial qualifying event.

Generally speaking, and other than under certain circumstances involving bankruptcy (as described above), in no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Adding New Dependents and Loss of Other Group Coverage While Enrolled in COBRA

If, while you are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA Continuation Coverage.

Any qualified beneficiary can add a new spouse or child to his or her COBRA Continuation Coverage. However, the only newly added family members who have the rights of a qualified beneficiary, such as the right to stay on COBRA Continuation Coverage longer in certain circumstances, are children born to, adopted, or placed for adoption with the covered employee.

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 but not enrolled for coverage under the terms of this Plan and, when enrollment was previously offered under the Plan and declined, the spouse or dependent must

have been covered under another group health plan or have had other health insurance. The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under the other 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 to pay premiums on a timely basis or termination of coverage for cause.

In any event, you must enroll the new spouse or dependent, or the spouse or dependent who has lost coverage under another group health plan, within 30 days of the event allowing for this "special enrollment" (*i.e.*, marriage, birth, adoption, placement for adoption or the exhaustion or termination of other coverage).

You must notify the Plan Administrator in writing of the termination of other coverage in order to add your dependents. Adding a spouse or dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage. Please contact the Plan Administrator for details.

PLEASE REMEMBER THAT THE PLAN WILL NOT SEND MONTHLY BILLS OR REMINDERS TO COVERED MEMBERS OR DEPENDENTS.

Termination of COBRA Continuation Coverage:

COBRA Continuation Coverage will terminate before the end of the applicable maximum period if:

- The required premium is not paid on time;
- A qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. If the plan does impose a pre-existing condition exclusion, then the individual may be allowed to continue his or her COBRA for the applicable maximum period or wait until the other Plan's pre-existing condition exclusion no longer applies to that individual. Contact the Plan Administrator for details.

- 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.
- The qualified beneficiary's COBRA Continuation Coverage was extended due to disability and the SSA had determined that the qualified beneficiary is no longer disabled.

If COBRA Continuation Coverage is terminated before the end of the maximum coverage period, the Plan Administrator will send you a written notice as soon as practicable following the Plan Office's determination that COBRA will terminate. The notice will set forth the reason why COBRA Continuation Coverage will be terminated early, the date of termination, and your rights to alternative individual or group coverage.

Full details of COBRA Continuation Coverage will be furnished to you or your dependents when the Plan Administrator receives notice that one of the qualifying events has occurred. **Therefore, we urge employees and dependents to contact the Plan Administrator as soon as possible after one of those events.**

Other COBRA Issues:

Confirmation of Coverage Before Election of or Payment for COBRA Continuation 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 election period but have not yet elected COBRA, 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 Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan 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 Plan Administrator.

Your Decision Concerning COBRA Continuation Coverage

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not receive COBRA Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you receive COBRA for the maximum time available to you.

Retirement and COBRA

At the time you retire, you will be sent a COBRA election notice. If you do not elect COBRA, you will have no other rights to COBRA Continuation Coverage under the Plan.

**PROCEDURES FOR PROVIDING
CERTIFICATES OF CREDITABLE COVERAGE**

Pursuant to the Health Insurance Portability and Accountability Act of 1996, you are entitled to request and receive a Certificate of Creditable Coverage (a “Certificate”) from the Doctors Council Benefit Plan at any point while you are covered under the Plan and up to 24 months after coverage ceases. Furthermore, if you later enroll in a different plan, you may authorize that plan to request a Certificate from the Plan.

In order to obtain a Certificate on behalf of yourself or your dependents, write to the Doctors Council Benefit Plan, 50 Broadway, 11th Floor, Suite 1101, New York, NY 10004 or call the Plan Office at (212) 532-7690. Be sure to include your current address, or if different and applicable, the address of your dependent(s).

Please be advised that in any event, you will also automatically be provided with a Certificate, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases.

OTHER IMPORTANT INFORMATION

This section includes:

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

Claims and Appeals Procedures:

This section describes the procedures for filing claims for benefits from the Doctors Council Benefit Plan B. 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 Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form. The appropriate claim form may be obtained from the Plan Office.

Simple inquiries about the Plan'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 Plan is not a claim for benefits.

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

- Member name
- Patient name
- Patient Date of Birth
- SSN of member
- Dates of Service
- CPT-4 (the code for physician services and other health care services)
- ICD-9 (the diagnosis code)
- CDT code (the code for dental services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address
- If treatment is due to accident, accident details.

When Claims Must Be Filed

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

- Disability Benefit claims (initial application) must be postmarked within 3 weeks of the onset of disability.
- Disability Benefit claims (follow-up reports) must be submitted monthly.
- The Plan's Physical Examination Benefit and Legal Services Benefit require that you contact the Plan Office first to verify eligibility, before making an appointment. No claim forms are required to be filed for these benefits.
- Healthcare Cost Reimbursement Benefit claims must be postmarked by December 31 in the year following the end of the Plan Year (December 31) to which the claims relate.

Where To File Claims

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

For Blood, Hearing Aid, Legal Services (Out-of-State), Mammography, Maternity/Adoption, Optical, Podiatry, Private Duty Nursing and Psychiatric Benefits, please mail claims to (and, for Physical Examination, Optical PPO Network and Legal Services (In-State) Benefits, obtain pre-certifications from:

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

For Dental Benefits, please mail claims to:

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

For Healthcare Cost Reimbursement Benefits, please mail claims to:

Administrative Services Only, Inc.
PO Box 9005
Lynbrook, NY 11563-9005
516-396-5500 800-537-1238 (telephone)

For Disability Benefits, please mail claims to:

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

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously authorized the individual to act on

your behalf. A form can be obtained from the Plan Office to designate an authorized representative. The Plan 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 Plan; that is, claims submitted for payment after health services and treatments 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 a 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 Benefit Plan 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.

Ordinarily, you will be notified of the decision on your post-service claim within 30 days from receipt of the claim by the appropriate organization (as described above). This period may be extended one time by the organization for up to 15 days if the extension is necessary due to matters beyond its 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 organization expects to render a decision.

If an extension is needed because the organization 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 organization reviewing your claim then has *15 days* to make a decision on the post-service claim and notify you of the determination.

Disability Claims

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

For Disability Claims, you and your physician must complete separate claim forms, both of which are available from the Plan Office. Both completed forms must be returned to the Plan within three weeks of the onset of your disability. The Plan will make a decision on the claim and notify you of the decision within *45 days*. If the Plan requires an extension of time due to matters beyond its control, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within *30 days* of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Plan notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

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

Notice of Decision

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

- The specific reason(s) for the determination.
- Reference to the specific Plan 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.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- 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 Plan 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 within *180 days* 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 organization which first reviewed the claim 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 organization for ensuring consistent decision-

making; or it constitutes a statement of Plan 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 reviewing organization 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 reviewer.
- Disability Claims: The Plan will decide your appeal and notify you in writing within 45 days of your request for review. Under special circumstances, an extension of time not exceeding 45 days may be granted for reasons beyond the control of the Plan. If such an extension is required, you will be advised in writing within the 45 days after receipt of your request for review of the special circumstances and the date a decision will be made.

Notice of Decision on Review

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

- The specific reason(s) for the determination.
- Reference to the specific Plan 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.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, 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 Plan to your claim, or a statement that it is available upon request at no charge.

You and your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor office and your State insurance regulatory agency.

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. You may also pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. 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:

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

Receive Information About Your Plan and Benefits:

Examine, without charge, at the Plan Office and at other locations if required by law, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Office, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Office may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA Continuation Coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you

may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the 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 is frivolous.

Assistance with Your Questions:

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

HIPAA's Privacy Rules:

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans like the Doctors Council Benefit Plan protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the Plan Office. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

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

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. Any health care providers (such as physicians, pharmacies and hospitals) will provide you with their own notices of privacy practices.

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

The Plan maintains a Notice of Privacy Practices which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Plan Office. If you have questions about the privacy of your health information please contact the Plan's Privacy Officer. If you wish to file a complaint about a privacy issue, please contact the Privacy Officer.

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 Plan, the Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan documents and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. 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 Plan, the Plan 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 Plan, 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 Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by Plan members and beneficiaries upon written request to the Plan Office, and is available for examination by Plan members and beneficiaries, as required by applicable law. Plan members 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.

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, dental, vision, and disability, as well as legal services benefits.

Type of Administration: Self-insured: dental benefits are administered by Self Insured Dental Services (SIDS) under contract.

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.