Dear Participant:

Since the last issue of the supplemental welfare benefits booklet was printed, there have been many changes to your supplemental welfare benefits program.

Please take the time to read this updated booklet and review the many benefits which have been improved or expanded and acquaint yourself with the new features added to your Plan of Benefits.

The Plans are designed to help defray the amount of money any participant must spend for supplemental welfare, legal, and other benefit needs. Each of the supplemental welfare, legal, and other benefits has different kinds and amounts of coverage. Sometimes there are limits on how much expense you can claim under one benefit in one year, or how often you can use that benefit in one year. There may be a small portion of the expense you must pay for yourself, before or after your benefits are paid. Please read this booklet carefully or call the Fund Office and check first, so you will know exactly what to expect and so you can receive the fullest possible coverage.

Over the years, federal and state legislation has mandated that workers and dependents, covered under plans such as these, be able to continue benefits coverage under certain circumstances. You will find that in one specific section (see Continuation of Coverage section) we share with you the procedures implemented by the Fund Office to meet these standards and/or to comply with such legislation.

We anticipate that the benefits chart found at the beginning of the Eligibility and Enrollment Section will help to highlight all the benefits and services provided by the Welfare Fund and Group Legal Fund of the Day Care Council-Local 205, D.C. 1707, which are available to you.

We urge you to keep this booklet handy along with the address and telephone number of the Fund Office. The Board of Trustees and the Union and Management organizations they represent and the Fund Office staff are very proud of the Plans. We thank you for giving us the opportunity to be of service to you and your family.

Sincerely,

Board of Trustees of the
Welfare and Group Legal Funds
Day Care Council, Local 205
District Council 1707, AFSCME, AFL-CIO

This booklet contains a summary in English of the supplemental benefits and services provided by the Welfare Fund and Group Legal Fund of the Day Care Council-Local 205, D.C. 1707. If you have difficulty understanding any part of this booklet, contact the Fund Office at 75 Varick Street, New York, NY 10013-1917. Office Hours are from 9:00 A.M. to 5:00 P.M., Monday through Friday. You may also call the Fund Office at (212) 925-0005 for assistance.

Este folleto contiene un resumen en Inglés, de sus beneficios y servicios suplementarios otorgados por el Welfare Fund and Group Legal Fund of the Day Care Council-Local 205, D.C. 1707. Si Ud. tiene alguna dificultad para entender cualquier parte del contenido de este folleto, por favor, visite nuestras oficinas ubicadas en 75 Varick Street, New York, NY 10013-1917. Las horas de Oficina son de 9:00 AM to 5:00 PM de Lunes a Viernes. Usted también puede llamar a la Oficina del Fund al número (212) 925-0005 por cualquier asistencia requerida.

Day Care Council – Local 205, D.C. 1707 Welfare Fund and Group Legal Fund

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Table of Contents

INTRODUCTION

What This Document Tells You

This document describes the hospital, dental, orthodontic (for eligible dependents only), TMJ appliance, prescription drug, optical, professional nursing, ambulance/ambulette, prosthetic, orthopedic and prescribed durable medical equipment/appliance, survivor, supplemental disability income benefit, tuition assistance and group legal services benefits for employees (and/or covered dependents) of unionized Day Care Centers that are contributors to and participants in the Day Care Council-Local 205, D.C. 1707 Welfare Fund and Group Legal Fund as provided in the Plan . The Plan described in this document is effective January 1, 2005, [except for those provisions that specifically indicate other effective dates].

This document will help you understand and use the benefits provided by the Plan. You should review it and also show it to those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the supplemental welfare benefits provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Fund Office.

The Day Care Council-Local 205, District Council 1707 Welfare Fund does not administer nor provide the Hospital and Medical insurance benefit options discussed in this document briefly on page 14. Enrollment in either the **Group Health Incorporated (GHI) Medical Plan** , which provides medical coverage only, or the **Health Insurance Plan/Health Maintenance Organization (HIP/HMO)**, which provides basic medical and hospital coverage, is through the Day Care Center where you are employed and is administered by the Mayor's Office of Operations, CityWide Central Insurance Program (CCIP). Complete details on the basic hospital and medical insurance options and benefits should be available from your Center, CCIP and the Insurance Carrier.

The Welfare Fund administers the enrollment of basic hospital benefits to participants and dependents that are covered under the Basic GHI-Medical Insurance Program. The hospital insurance benefits are provided under a group contract held with Empire Blue Cross and Blue Shield. The enrollment into the Empire Blue Cross and Blue Shield hospital insurance program is administered by the Welfare Fund Office on behalf of the Mayors Office of Operations, CityWide Central Insurance Program (CCIP). In addition, the Welfare Fund provides an extended benefits rider for hospital coverage.

Remember, not every expense you incur for Supplemental Welfare Benefits is covered by the Plan. Be sure to read the Exclusions section in each of the benefit description sections.
All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information from the Fund Office at 212-925-0005.

As the Plan is amended from time to time, you will be sent information explaining the changes. If the later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

The Welfare Fund and Group Legal Fund of the Day Care Council- Local 205, District Council 1707 are Taft-Hartley ERISA funds providing insured and self-insured supplemental welfare and legal service benefits to approximately 6300 workers and dependents who are employed at over 350 day care centers (Employers), which are a party to a collective bargaining agreement with C.S.A.E.U.-D.C. 1707 Local 205 (Union), either directly or through the employer association, Day Care Council of New York, Inc.

Each Fund is a separate legal and financial entity under the terms of its own Agreement and Declaration of Trust. A Board of Trustees is responsible for the administration of both Funds. The Board has an administrative office, an administrator, and staff responsible for the day-to-day operations of the Funds.

The Fund Office is charged with the responsibility for the smooth functioning and delivery of benefits to its day care participants and for establishing procedures to accomplish this goal. The Fund Office is also responsible for the billing and collection of employer contributions and basic hospital insurance premiums from participating day care centers. The contribution income funds the cost of the benefit plans.

The Welfare Fund

The contributions to the Welfare Fund are made by each employer in accordance with the current collective bargaining agreement between the Union, CSAEU-D.C. 1707, Local 205 and the Day Care Council of New York, Inc. or Day Care Center. The collective bargaining agreements require annual contributions to the Fund to be paid at a fixed rate per month. The Welfare Fund Office will provide participants, upon written request, with up-to-date information as to whether a particular center is contributing to the Plan on behalf of employees working under the collective bargaining agreement.

Contributions are held in a Trust Fund for the purpose of providing benefits to covered participants and beneficiaries and for defraying reasonable administrative expenses related to the administration of the Plan.

Who Pays for These Benefits?

The Welfare Fund's supplemental welfare benefits, tuition assistance benefits, and the Group Legal Fund services are available to eligible day care center employees at absolutely no cost to them. The cost of these benefits is funded by contributions, which are paid by each participating day care center on behalf of its employees.

Delinquent Contributions

Contributions to the Welfare Fund are made by each employer center on behalf of the employees working under the Collective Bargaining Agreement. Should an employer fail to make monthly contributions on behalf of its employees for two (or more) months, Welfare Fund benefits will cease for those employees and the employer will be liable for any loss of benefits incurred by its employees and dependents as a result of its delinquency.

The Legal Fund

The Day Care Council- Local 205, D.C.1707 Welfare Fund has agreed to contribute to the Day Care Council-Local 205, D.C. 1707 Group Legal Fund up to $50 per covered participant per year. These contributions are from the accumulated reserves of the Welfare Fund. These contributions fund the cost of the Group Legal Fund benefits.

Supplemental Welfare and Legal Benefits are provided from the assets, which are accumulated under the provisions of the Collective Bargaining Agreement and each Trust Fund Agreement. Such assets are held in the Trust Funds for the purpose of providing benefits to eligible participants and covered dependents, as well as defraying reasonable administrative expenses.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

The Plans' requirements with respect to eligibility, as well as circumstances that may result in disqualification, ineligibility, denial or loss of any benefit are fully described in this booklet.

RIGHT TO AMEND OR TERMINATE PLAN

The Trustees (or any duly authorized agents of the Trustees) reserve the right, in their sole and absolute discretion, to terminate the Plan in whole or in part at any time and for any reason; to modify or amend the Plan in whole or in part at any time and for any reason, including any related documents and underlying policies in such manner as may be duly authorized by the Trustees; and to change or discontinue the type and amounts of benefits offered by the Fund and the eligibility rules for extended or accumulated eligibility (even if extended eligibility has already accumulated) to participants (including retirees) and their beneficiaries.

If the Plan terminates, the Trustees will apply the assets of the Fund to provide benefits or otherwise to carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been disbursed.

Benefits provided through the Fund and eligibility rules for active, retired, or disabled participants:

- are not guaranteed,
- may be changed or discontinued by the Board of Trustees,
- are subject to the rules and regulations adopted by the Board of Trustees,
- are subject to the Trust Agreement, which establishes and governs the Fund operations, and
- are subject to the provisions of the group insurance policies purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time a claim occurs.

An Enrollment Card **MUST BE ON FILE** at the Welfare Fund Office. If we do not have this card, we will have unavoidable problems providing benefits to you and your dependents. See the "How to Enroll" section for more information.

Eligibility and Enrollment

Benefits Available

The following Supplemental Welfare and Legal Benefits are available at no cost to employees of unionized Day Care Centers that contribute to and participate in the Day Care Council-Local 205, D.C. 1707 Welfare Fund:

- Hospital Extended Coverage Rider (ECR)
- Dental Benefits
- Orthodontic Benefits (for eligible dependents only)
- TMJ Disorder Appliance
- Prescription Drugs
- Optical Benefit
- Professional Nursing
- Ambulance / Ambulette
- Prosthetic, Orthopedic, and Prescribed Durable Medical Equipment/Appliances
- Survivor Benefit
- Continuation of Supplemental Welfare Fund Coverage While Disabled
- Supplemental Disability Income
- Tuition Assistance
- Group Legal Services

BENEFITS AVAILABLE & BEGINNING DATES OF COVERAGE

Basic Medical and Hospital Benefits Provided by CitiWide Central Insurance Program (CCIP)

You have a choice to enroll in one of two medical plan options. You may enroll in the Group Health Incorporated (GHI), which provides medical coverage only, or the Health Insurance Plan/Health Maintenance Organization (HIP/HMO), which provides hospital and medical coverage.

Your benefits under the GHI or the HIP/HMO option begin on the first day of the month following 60 days of employment. See the chart at the end of this section.

Enrollment in either GHI or HIP/HMO is arranged through the Day Care Center where you are employed and is administered by the Mayor's Office of Operations, CityWide Central Insurance Program (CCIP). The Day Care Council- Local 205, DC 1707 Welfare Fund does not administer nor provide the medical plan benefit, nor answer questions regarding your eligibility for medical coverage.

For further information or answers to questions you may have about the GHI-Medical or HIP/HMO hospital/medical insurance programs contact: CityWide Central Insurance Program at (212) 788-8142.

For participants who choose GHI medical coverage, hospitalization benefits are provided under a group contract held with Empire Blue Cross and Blue Shield. The basic hospital benefits are insured by the **CityWide Central Insurance Program (CCIP)** and enrollment is administered by the Welfare Fund. Your hospital benefits will begin on the first day of the month following 60 days of employment. The basic hospital benefits are available only to participants and dependents who are covered under the Basic GHI-Medical Insurance Program administered by CCIP.

Welfare Fund Benefits

If you elect to enroll in the GHI-Medical Insurance Program with the basic hospital benefits provided by Empire Blue Cross Blue Shield, the Welfare Fund provides an extended benefits rider for hospital coverage extending the hospital days under the group contract held with Empire Blue Cross and Blue Shield. The extended hospital benefits will also begin on the first day of the month following 60 days of Welfare Fund enrollment.

The following Welfare Fund benefits begin on the 1st day of the month following 90 days of Welfare Fund enrollment. This waiting period is applicable to new employees, rehired employees and employees returning from a leave of absence that is beyond the approved period.

- Dental Benefit
- Orthodontic Benefits (for eligible dependents only)
- TMJ Appliance Benefit
- Prescription Drugs
- Optical Benefit
- Professional Nursing
- Ambulance/Ambulette
- Prosthetic, Orthopedic, and Prescribed Durable Medical Equipment/Appliances
- Survivor Benefit
- Continuation of Supplemental Welfare Fund Coverage While Disabled
- Supplemental Disability Income

In addition, the following benefit programs have their own unique eligibility requirements, which dictate when benefit payments or services can be dispensed.

- Tuition Assistance benefits become payable after ten (10) consecutive months of active participation in the Welfare Fund.

  Please refer to the Tuition Assistance Benefit section for more information.
- Group Legal Services are provided by the D.C.C.-Local 205, D.C. 1707 Group Legal Fund after the completion of twelve (12) consecutive months of active participation in the Welfare Fund. Please refer to the Group Legal Services section for more information.

SUMMARY OF WHEN BENEFITS BEGIN

Benefit	Effective Date of Coverage
GHI or HIP/HMO Basic Benefits Plan (Administered and provided by CCIP.)	1st day of the month following 60 days of employment.
Basic Hospital Insurance and extended coverage rider if enrolled in the GHI medical plan provided under contract with Empire Blue Cross and Blue Shield.	1st day of the month following 60 days of Welfare Fund enrollment.
Dental Orthodontic Benefits (For eligible dependent children only) TMJ Appliance Benefit Prescription Drugs Optical Benefit Professional Nursing Ambulance/Ambulette Prosthetic, Orthopedic, & Prescribed Durable Medical Equipment/Appliances Survivor Benefit Continuation of Supplemental Welfare Fund Coverage While Disabled Supplemental Disability Income	1st day of the month following 90 days of Welfare Fund enrollment.
Tuition Assistance	Benefits become payable after ten (10) consecutive months of active participation in the Welfare Fund.
Group Legal Services	Provided after the completion of twelve (12) consecutive months of active participation in the Welfare Fund.

Please note, the effective date for benefits as stated above is based on the timely receipt of the enrollment card and required documents. Any delay in submitting the enrollment card to the Welfare Fund for processing will affect and delay the effective date for benefits. This means that whenever an enrollment card is received late (beyond 30 days from the date of hire or return to work), the eligibility for benefits will be based upon the date that the completed, signed, and Center-verified enrollment card (and required documents) is received at the Welfare Fund Office.

WHO IS ELIGIBLE FOR WELFARE FUND BENEFITS?

Your Eligibility

All verified permanent and non-administrative employees who work in an Administration for Children's Services/ Agency for Child Development (ACS/ACD) funded Day Care and/or Family Day Care Centers that are a party to a Labor-Management Contract with the Community and Social Agency Employees Union, District Council 1707, Local 205, AFSCME and who work a minimum of 15 hours a week, are eligible for the Welfare Fund and Group Legal Fund benefits described in this booklet.

If You Transfer to Another Center

Employees who transfer from one unionized Participating Day Care Center to another unionized Participating Day Care Center will be covered on the 1st day of the month following the 1st working day at the new Center, provided they were covered by the previous Center, contributions were paid by that Center through the last day worked and the employee's break in service does not exceed 31 days from the last day worked.

Employees changing employment from one unionized Participating Day Care Center to another must fill out an enrollment card for Welfare Fund benefits at their new Center.

Your Dependents' Eligibility

For benefits provided by the Welfare Fund, your eligible dependents include:

- Your spouse to whom you are legally married,
- Your unmarried dependent children (natural, adopted or placed for adoption) until the end of the calendar year in which they reach age 23,
- Your unmarried dependent step-children until the end of the calendar year in which they reach age 23,
- Your unmarried children or step-children over age 23 who are unable to do any work to support themselves because of mental illness, developmental disability or mental retardation as defined by New York Mental Hygiene Law, or physical handicap. The incapacity must have started before the child reached age 23, and may have to be certified by a physician.

You must submit proof of dependency status for all persons when you enroll them for Fund coverage. These proofs include copies of marriage certificates, birth certificates, and court orders of adoption.

Please note, the effective date for benefits as stated above is based on the timely receipt of the enrollment card and required documents. Any delay in submitting the enrollment card to the Welfare Fund for processing will affect and delay the effective date for benefits. This means that whenever an enrollment card is received late (beyond 30 days from the date of hire or return to work), the eligibility for benefits will be based upon the date that the completed, signed, and Center-verified enrollment card (and required documents) is received at the Welfare Fund Office.

HIPAA Special Enrollment

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your new dependent(s), provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you did not enroll your spouse and/or any dependent child(ren) for coverage because they had health coverage under any other health insurance policy or program or employer plan and your spouse and/or dependent child(ren) cease to be covered by that other health insurance policy or plan, you may enroll your spouse and/or dependent child(ren) within 30 days after termination of their coverage under that other health insurance policy or plan.

Qualified Medical Child Support Order (QMSCO)

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMSCO) or a National Medical Support Order (NMSO)– a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office can provide more details about enrolling your children in such cases.

COORDINATION OF BENEFITS

How Duplicate Coverage Occurs

This section describes your responsibilities if you or your dependent(s) are covered by another plan, in addition to this plan. For purposes of this Coordination of Benefits section, the word "plan" refers to any group or individual plan, policy, or contract, whether insured or self-insured that provides benefits similar to those outlined in this booklet to the Covered Individual. A "group plan" provides its benefits or services to employees, retirees or participants of a group who are eligible for and have elected coverage. An "individual plan" provides its benefits or services to individuals or families who have purchased coverage. The plan may be among one of the following:

(a) Another employer, welfare fund, group, or individual health care plan; or

(b) Medicare; or

(c) Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs,

(d) motor vehicle coverage including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or

(e) any coverage provided by a federal, state or local government or agency; or

(f) Workers' compensation.

When you or a dependent have coverage in addition to this Plan, the Fund will "coordinate benefits" with the other plan. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the Fund's allowed charge. Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

(a) Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of rules in a specific sequence. This Plan uses the rules established by the National Association of Insurance Commissioners (NAIC) which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.

(b) When two group plans cover the same person, the following rules determine which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not apply or establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

(i) The plan that covers a person as an employee, participant or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

(ii) There is one exception to this rule. If the person is also a Medicare beneficiary, the plan that covers the person as a dependent pays first and Medicare pays second. The plan that covers the person other than as a dependent pays second and Medicare pays first.

Rule 2: Dependent Child Covered Under More Than One Plan

(i) The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second.

(ii) If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

(iii) The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

(iv) If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first.

(v) If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

(i) The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

Rule 4: Continuation Coverage

(i) If a person whose coverage is provided under COBRA is also covered under another plan, the plan that covers the person as an employee, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

(ii) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(iii) If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

(i) If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid for each claim as it is submitted had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by the Plan. "Allowable expenses" do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB

(a) To administer COB, the Plan reserves the right to:

(i) exchange information with other plans involved in paying claims;

(ii) require that you and/or your spouse or your Health Care Provider furnish any necessary information;

(iii) reimburse any plan that made payments this Plan should have made; or

(iv) recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

Coordination with Medicare

(a) **Entitlement to Medicare Coverage**
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.

(b) **Medicare Participants May Retain or Cancel Coverage Under This Plan**
If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan.
If you and/or any of your Dependents are covered by both this Plan and by Medicare, as long as you remain actively employed, your medical expense coverage will continue to provide the same benefits and your contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.
If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the "COBRA Continuation Coverage" section for more information.
If any of your Dependents are covered by Medicare and you cancel that Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage.

(c) **Coverage Under Medicare and This Plan When You Are Totally Disabled**
If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

(d) **Coverage Under Medicare and This Plan When You Have 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 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Coordination With Other Government Programs

(a) **Medicaid**: If a Covered Individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

(b) **TRICARE**: If a Covered Dependent is covered by both this Plan and TRICARE, the program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days, TRICARE is primary and this plan is secondary.

(c) **Veterans Affairs Facility Services**: If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility for a condition due to a military service-related illness or injury, benefits are not payable by the Plan. If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition, benefits are payable by the Plan according to its terms.

(d) **Motor Vehicle Coverage Required by Law**: If a Covered Individual is covered for hospital, medical, optical or dental benefits by both this Plan and any motor vehicle coverage that is required by law, including but not limited to no-fault, uninsured motorist or underinsured motorist, the motor vehicle coverage pays first, and this Plan pays second.

(e) **Other Coverage Provided by State or Federal Law**: If a covered individual is covered by

both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Coordination With Workers' Compensation

This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law.

HOW TO ENROLL

1. Go to the Center Bookkeeper and obtain a Welfare Fund Enrollment Card.
2. Fill out and sign the card.
    a. If you are enrolling dependents, you will also need to include the name, birth date, relationship, and social security number of all eligible dependents.
    b. Copies of the following documents are also required and must accompany the enrollment card: birth certificate(s), marriage certificate, and social security card(s).
3. The Center Director and/or Bookkeeper must also fill out and sign the card, verifying the applicant's employment status.
4. The Center Director and/or Bookkeeper will forward the enrollment card and documents to the Welfare Fund for processing. The enrollment card and required documents must be received by the Welfare Fund within 30 days from the date of hire. Upon receipt of the enrollment card and required documents, the Fund Office will process the enrollment for Welfare Fund and Legal Fund benefits.

Changes in Your Information and Status

You must inform the Fund Office of any change in your and/or your dependent's information on file, including but not limited to any information you or they may have that may affect eligibility for coverage under the Plan.

This includes, but is not limited to:

1. Change of name.
2. Change of address.
3. Marriage, divorce, or death of you or any covered spouse or dependent child.
4. Addition of new dependent(s) due to birth/adoption/placement for adoption.
5. Any information regarding the status of a dependent child, including, but not limited to:
    - The dependent child reaching the age where he or she is no longer covered by the Plan;
    - The existence of any physical or mental handicap.
    - Medicare enrollment or disenrollment.
6. The existence of other supplemental health or dental benefits coverage.
7. Social Security disability award or termination.

You must provide this information as soon as possible, because, in some instances, the date on which benefit coverage may begin will be affected. Notice of the above information should be sent, **in writing**, to the Fund Office.

LEAVE OF ABSENCE

Your coverage may continue during certain approved leaves of absence, explained below.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave from your Employer during any 12-month period for:

- the birth, adoption, or placement with you for adoption of a child;
- providing care for a spouse, child, or parent who is seriously ill; or
- your own serious illness.

You are generally eligible for a leave under the FMLA if you:

- have worked for a covered Employer for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 employees are employed by the Employer within 75 miles.

The Fund will maintain your eligibility status until the end of the leave, provided the contributing Employer properly grants the leave under FMLA and the contributing Employer makes the required notification [and payment] to the Fund. Of course, any changes in this Plan's terms, rules or practices that go into effect while you are on leave apply to you and your covered dependents, the same as to active employees and their covered dependents. If you do not return to covered employment after your leave ends and you lose coverage as a result, you are entitled to COBRA continuation coverage when your leave ends. Call your Employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

Military Leave

If you are on active military duty for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active military duty for more than 31 days, USERRA permits you to continue hospital insurance (basic & extended), dental, orthodontic, TMJ appliance benefit, prescription drugs, optical benefit, ambulance/ambulette, professional nursing, prosthetic, orthopedic and prescribed durable medical equipment/appliances coverage for you and your covered dependents at your own expense for up to 18 months. This continuation right operates in the same way as COBRA. See the section later in this booklet for a full explanation of the COBRA coverage provisions. In addition, your dependent(s) may be eligible for health care coverage under the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS). This Plan will coordinate coverage with CHAMPUS.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to work with a contributing Employer, provided that you return to employment within:

1. ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or
2. fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or
3. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two years. Call your Employer if you have questions regarding military service leave. Call the Fund Office if you have questions regarding coverage during such leave.

Reinstatement of Coverage After Leaves of Absence

If your coverage ends while you are on an approved FMLA leave or USERRA military leave, your coverage will be reinstated on the day you return to active employment (see the Military Leave section above for more details). All annual and lifetime Plan benefit maximums include benefits that were paid prior to the leave of absence.

Return From Leave

As negotiated by the Labor-Management Contract with the Community and Social Agency Employees Union, District Council 1707, Local 205, AFSCME, employees who return to work from an approved leave of absence within the guidelines shown below will be eligible for benefits on the **first of the month following their date of return**.

Maternity/ Paternity Leave	18 months
Disability Leave	6 Months
Workers Compensation	6 Months

Please note that the effective date for benefits as stated above is based on the timely receipt of the Welfare Fund Enrollment Card and required documents. Any delay in submitting the Enrollment Card to the Welfare Fund for processing will affect and delay the effective date for benefits. This means that whenever an Enrollment Card is receive late (beyond 30 days from the date of hire or return to work) eligibility for benefits and the effective date for the start of your benefits will be based on the date your completed Enrollment Card and required documents are received by the Fund Office.

WHEN COVERAGE ENDS

For You

Your eligibility for benefits ends on the **last day of the month in which you stopped working**, regardless of any payment(s) made to you by the center for earned and unused vacation time. At the same time that benefits end for the covered employee, they also end for all dependents.

Example:
You stop working on April 15th. Your eligibility for benefits ends on April 30th, even if you are being paid for unused vacation days through May or beyond.

An active employee is considered **ineligible** to receive benefits for any of the following reasons:

Failure to work the required number of hours to maintain participation in Welfare Fund benefits, resignation, retirement, sabbatical, maternity (non-disability)/paternity leaves, discharge, personal leaves of absence without pay for more than one (1) month, end of twelve (12) week maximum Family & Medical Leave (FMLA) or end of six (6) month maximum Disability Leave.

Example:
Your work schedule changes from 20 hours a week to 14 hours a week on June 2nd. Your eligibility for benefits ends on June 30th. You may then be eligible for continuation of coverage under COBRA.

An employee suspended with pay is eligible to continue Welfare Fund enrollment while on suspension, provided the Center continues contributions on behalf of the suspended employee.

For Your Dependents

Dependent coverage ends on the last day of the month in which:

- You do not work the required number of hours to maintain participation in the Fund's supplemental welfare benefits program; or
- You (the active participant) end employment for any reason; or
- Your (the active participant's) own coverage ends; or
- You (the active participant) die, get divorced, become legally separated, or become entitled to Medicare (and voluntarily drop Fund coverage) or
- Your dependent child ceases to be eligible for Fund coverage, for example, he or she marries or reaches the maximum age limit for coverage.

Under certain circumstances when coverage for you and/or your covered dependents would otherwise end, you and/or they may be able to continue coverage under COBRA. See the section entitled "Continuation of Coverage" for details.

OTHER PLAN INFORMATION

Maternity Care

Effective January 1, 1998, the Plan generally may not, under federal law, restrict benefits for any hospital length or stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and health insurance carriers may not, under federal law, require that a provider or health care practitioner obtain authorization from the Plan or insurance company for prescribing a length of stay not in excess of the above periods.

Breast Reconstruction Surgery Benefits Following Mastectomy

Under the Women's Health and Cancer Rights Act of 1998, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery effective January 1, 1999 for this Plan. Therefore, members and dependents who receive benefits under this Plan in connection with a mastectomy, and who elect breast reconstruction, will be covered in a manner determined in consultation with the attending physician and the patient, for;

- Reconstruction of the breast on which the mastectomy is performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedomas.

Coverage for the mastectomy-related service or benefits will be subject to the same copayment or coinsurance provisions that apply with respect to other medical or surgical benefits provided under your Plan.

Consult the **Group Health Incorporated (GHI) Basic Benefits Plan** and **Empire Blue Cross Blue Shield** booklet or the **Health Insurance Plan/Health Maintenance Organization (HIP/HMO) Basic Benefits Plan** booklet regarding coverage details about maternity and post-mastectomy breast reconstructive surgery benefits.

BASIC HOSPITAL & MEDICAL INSURANCE BENEFITS PROVIDED BY CITYWIDE CENTRAL INSURANCE PROGRAM (CCIP)

The Day Care Council-Local 205, District Council 1707 Welfare Fund does not administer nor provide the Basic Hospital and Medical Benefit. Enrollment in the insurance options discussed briefly on this page, is through the Day Care Center where you are employed and is administered by the Mayor's Office of Operations, CityWide Central Insurance Program (CCIP). Complete details on the basic medical options are available from your Center, CCIP and the Health Care Carrier. You must contact the Day Care Center where you are employed, CCIP and/or the Health Care Provider for any detailed information not discussed below regarding the Basic Hospital & Medical Insurance Benefits provided by CityWide Central Insurance Program (CCIP).

Day Care Center employees who work 15 hours or more per week in an Administration for Children's Services/Agency for Child Development (ACS/ACD) funded and permanent day care position, have a choice to enroll in the **Group Health Incorporated (GHI) Basic Benefits Plan** or the **Health Insurance Plan/Health Maintenance Organization (HIP/HMO) Basic Benefits Plan**. Your selection should be made when you first become employed or during an "open enrollment period" held once each year.

Group Health Incorporated (GHI) Basic Benefits Plan: Provides medical coverage only. The GHI Plan is an insurance reimbursement program, which allows you to choose your own medical providers. Through GHI, you and your eligible dependents, are covered for medical services and reimbursed for such expenses based upon a set fee schedule. For further information on your and/or your dependent(s) eligibility for GHI and health care services through GHI, please contact the CityWide Central Insurance Program (CCIP) at (212) 788-8142. You can also contact GHI at the GHI Subscriber Service at (212) 501- 4444.

Health Insurance Plan/Health Maintenance Organization (HIP/HMO) Basic Benefits Plan: Provides hospital and medical coverage. The HIP/HMO Basic Benefits Plan is a prepaid hospital and medical service program. You and your eligible dependents must use participating network doctors or health centers and approved hospitals to receive the comprehensive health services. Basic hospital and medical care is available to you and your eligible dependents. For more information on your dependent(s) eligibility for HIP/HMO and health care services through HIP/HMO, please contact the CityWide Central Insurance Program (CCIP) at (212) 788-8142. You can also contact HIP/HMO Member Services at 1-800-HIP TALK (447-8255).

For detailed information or answers to questions you may have about the **Group Health Incorporated (GHI) Plan** and/or the **Health Insurance Plan/Health Maintenance Organization (HIP/HMO)** regarding:

- Your eligibility
- Dependent eligibility
- Change of family status
- End of benefit coverage
- Enrollment and/or open enrollment
- Terms and conditions for coverage of medical tests/devices/procedures
- Schedule of benefits
- Coverage and limitations for emergency care treatment
- Medical exclusions
- Filing of claims
- Claims and appeals procedures

Contact the City Wide Central Insurance Program (CCIP) and/or the Health Care Provider. The Day Care Council-Local 205, District Council 1707 Welfare Fund does not administer nor provide the medical insurance options discussed in the section.

SUMMARY OF BENEFITS AND ELIGIBILITY

Benefit	Participant Eligibility	Dependent Eligibility
Basic Group Hospital Benefits and extended coverage rider if enrolled in GHI medical plan. Provided under contract with Empire Blue Cross and Blue Shield Effective Date of Coverage: 1st day of the month following 60 days of Welfare Fund enrollment.	All verified permanent and non-administrative employees who work in ACS/ACD funded Day Care and/or Family Day Care Centers that are a party to a Labor-Management Contract with the Community and Social Agency Employees Union, District Council 1707, Local 205, AFSCME and who work a minimum of 15 hours a week are eligible	• Your spouse to whom you are legally married. • Your unmarried dependent children (natural, adopted or placed for adoption) until the end of the calendar year in which they reach age 23, • Your unmarried dependent stepchildren until the end of the calendar year in which they reach age 23, • Your unmarried children or stepchildren over age 23 who are unable to do any work to support themselves because of mental illness, developmental disability or mental retardation as defined by New York Mental Hygiene Law, or physical handicap. The incapacity must have started before the child reached age 23, and may have to be certified by a physician.
Dental Insurance TMJ Appliance Benefit Prescription Drugs Optical Benefit Professional Nursing Ambulance/Ambulette Prosthetic, Orthopedic, & Prescribed Durable Medical Equipment/Appliances Effective Date of Coverage: 1st day of the month following 90 days of Welfare Fund enrollment.		
Orthodontic Benefits Effective Date of Coverage: 1st day of the month following 90 days of Welfare Fund enrollment.	Not Eligible	• Your unmarried dependent children (natural, adopted or placed for adoption) until the end of the calendar year in which they reach age 23, • Your unmarried dependent stepchildren until the end of the calendar year in which they reach age 23.
Tuition Assistance	Benefits become payable after ten (10) consecutive months of active participation in the Welfare Fund	Not Eligible
Group Legal Services	Provided after the completion of twelve (12) consecutive months of active participation in the Welfare Fund.	Not Eligible

Please note, the effective date for benefits as stated above is based on the timely receipt of the enrollment card and required documents. Any delay in submitting the enrollment card to the Welfare Fund for processing will affect and delay the effective date for benefits. This means that whenever an enrollment card is received late (beyond 30 days from the date of hire or return to work), the eligibility for benefits will be based upon the date that the completed, signed, and Center-verified enrollment card (and required documents) is received at the Welfare Fund Office.

HOSPITAL BENEFITS UNDER THE EMPIRE BLUE CROSS AND BLUE SHIELD INSURANCE PROGRAM

General Information

For participants who choose GHI medical coverage, hospitalization benefits are provided under a group insurance contract with Empire Blue Cross and Blue Shield. This basic hospital benefit is sponsored by the **CityWide Central Insurance Program (CCIP)** and the enrollment is administered by the Welfare Fund. The Welfare Fund provides the rider extending hospital days and enhancements. The basic hospital benefits are available to participants and dependents who, are covered under the Basic GHI-Medical Insurance Plan.

Participants who choose to enroll in the Health Insurance Plan/Health Maintenance Organization (HIP/HMO) Basic Benefits Plan have no further basic and extended hospital benefits other than the coverage provided by HIP/HMO through CCIP. The participants and dependents enrolled in the HIP/HMO are **NOT** eligible for the basic and extended hospital benefits provided under a group contract held with Empire Blue Cross and Blue Shield.

The Welfare Fund administers the enrollment of hospital benefits to participants and dependents who, are covered under the Basic GHI-Medical Insurance Program. For information on you and or/your dependent's eligibility and beginning date of coverage, please refer to the Eligibility section of this document. You can also call the Fund Office to obtain information about your eligibility and enrollment status. The Empire Blue Cross and Blue Shield program only covers in-hospital service expenses for up to 120 full benefit days. The Welfare Fund provides the rider extending hospital days another 180 days at 50%. Please call Empire Blue Cross and Blue Shield at 1-800-553-9603 with questions about services and claims.

A detailed description of the benefits provided by Empire Blue Cross and Blue Shield is found in the separate Group Hospital Insurance Benefit Booklet.

The CityWide Central Insurance Program (CCIP) provides you and your eligible dependents with coverage for hospital benefits, which are insured by Empire Blue Cross and Blue Shield.

For more details about your Empire BlueCross and BlueShield benefits, including coverage exclusions and limitations, please read the separate coverage description prepared by Empire Blue Cross and Blue Shield. A copy of this booklet is mailed to all Welfare Fund participants who have chosen the basic GHI-Medical insurance option, and is also available free of charge upon request by calling the Fund Office at (212) 925-0005.

DENTAL BENEFITS

As a participant of the Day Care Council-Local 205, District Council 1707 Welfare Fund, you and your covered dependents are enrolled in the Group Health Incorporated (GHI) dental benefit program. For information on your and your dependent's eligibility and beginning date of coverage, please refer to the section entitled "Who is Eligible for Welfare Fund Benefits?" described earlier in the booklet. The dental benefit, administered by Group Health Incorporated, provides access to a network of approximately 91 participating dental providers..

Regular Dental Service

When you use the services of a participating GHI dentist or a participating Dental Health Facility, most of the services below are paid in full. Participating Dentists have agreed to wait for GHI to pay them directly. GHI provides benefits for the services listed below:

- Examination with X-rays and cleaning
- Fillings
- Surgery of the mouth, including extractions
- Prosthetic services
- Gum treatments
- Root canal therapy (nerve removal and treatment)
- Emergency treatment
- Anesthesia in the hospital
- Specialist consultations

How To Obtain Benefits From a GHI Participant Dentist

1. Choose a GHI-participating dentist. To secure the name and address of these dentists or a participating dental health facility, please call GHI at (212) 501-4443.
2. Show your GHI-Dental identification card to the GHI-participating dentist before services are rendered.
3. Fill out and sign your part of the GHI-Dental claim form. The participating dentist will fill out and sign the dentist's part and mail the claim form to GHI.

Benefits for Services Rendered By a Non-Participating Dentist

GHI will help pay for dentists' bills for you and/or your eligible dependents. You may choose any dentist, anywhere. The non-participating dentists have no agreement with GHI. You must first pay the dentist directly. GHI will send its reimbursement check to you. The reimbursement payments for the dental benefits are based upon the GHI payment schedule for covered services under our Group Dental Insurance Contract. You will be responsible for any charges in excess of the GHI payment schedule.

OUTLINE OF REGULAR DENTAL BENEFITS

This is a brief description of your regular Dental Benefit Program. Payment for covered services includes necessary preparatory and related services such as X-rays, local anesthesia, and aftercare. The terms and conditions governing the insurance are those set forth in the GHI Dental Group Contract.

EXAMINATIONS, X-RAYS, CLEANING	GHI PAYS
Examination and charting, one per calendar year	$12.00
Prophylaxis (cleaning), two per calendar year	
12 years and over	18.00
Less than 12 years	18.00
14 standard X-rays (full-mouth series), one every five years	24.00
4 bitewing X-rays each year	14.00
FILLINGS AND RESTORATIONS	
Silver Amalgam	
One surface	15.00
Two surfaces, same tooth	20.00
Three or more surfaces, same tooth	26.00
Synthetic Porcelain, Acrylic and Composites	
Composites Per Filling	21.00
Maximum per tooth	30.00
Anterior Crowns cast gold crown	150.00
Full cast gold crown	162.00
with acrylic veneer	165.00
with porcelain veneer	210.00
Porcelain jacket crown	150.00
Acrylic or vinyl jacket crown, laboratory processed	120.00
Shell crowns:	
gold	60.00
steel	45.00
EXTRACTIONS	
Impacted Teeth	
Complete covered by bone	96.00
Soft tissue impaction	48.00
Partial bony impaction	60.00
Difficult extraction, requiring some bone removal, flap and surfaces	48.00
Routine Extraction	21.00
ORAL SURGERY	
Removal of cyst, including necessary tooth extraction	81.00
Alveotectomy, maximum per jaw	72.00
Excision of tissue for biopsy, including report	24.00
Rooth Canal Therapy	
First canal, per tooth	115.00
Two or more canals, same tooth, per tooth	140-185.00
Apicoectomy: single procedure	60.00
Apicoectomy, including root canal filling, and/or root-end amalgam	105.00
PERIODONTICS	
Per treatment	25.00
Maximum, 2 treatments per calendar year by General Practitioner	50.00

PERIODONTICS	GHI PAYS
Maximum, 5 treatments per calendar year by Dental Specialist (GHDI will pay no more than $125.00 per calendar year in combination for Periodontics.)	$12.00
PROSTHETIC SERVICES	
Dentures Full and Partial	
Full, permanent, each jaw	270.00
Partial, bilateral acrylic or comparable base, 2 or more full clasps and rests, each jaw	180.00
Partial, bilateral, chrome-cobalt alloy, 2 or more full cast clasps with occlusal rests, acrylic attachments and porcelain or acrylic teeth, each jaw	285.00
Adding teeth to a partial denture to replace natural teeth:	
First tooth	42.00
Each additional tooth	15.00
Obtuator (not including denture)	75.00
One of the following three procedures, related to one denture, every three years	
Laboratory rebasing, or	75.00
Chairside rebasing, or	60.00
Duplication of denture (jump)	90.00
Dentures, Unilatural	
Steel with clasps and lugs (Nesbett):	
One tooth	100.00
Two teeth	125.00
Three teeth	160.00
Abutments: If any tooth (front or back) is used as a primary abutment (support) for a fixed bridge, then the full scheduled allowance will be paid for the crown on that tooth:	
cast gold crown	150.00
Full cast gold crown	162.00
with acrylic veneer	165.00
with porcelain veneer	210.00
Porcelain jacket crown	120.00
Acrylic or vinyl jacket crown, laboratory processed	120.00
Inlay used as abutment, 2 surface	126.00
Inlay used as abutment, 3 surface	156.00
Pontics	
Tru-pontic (porcelain or acrylic) Facing with bast backing	210.00
Pontic of other type	162.00
PALLIATIVE SERVICES	
Emergency visit for relief of pain — one visit per calendar year	12.00

Other Dental Benefits

In Hospital Anesthesia

If you receive services, as a hospital patient, that are covered by GHI Dental, and you use a private anesthesiologist, GHI Dental will pay $18.00 per 15 minutes of anesthesia administration.

Specialist Consultations:

If your general dentist requires a consultation with a dental specialist, GHI Dental will pay $35.00 if:

1. It is the first consultation in that specialty field in that calendar year
2. The specialist does not perform any other service within 3 months of the consultation.

Dental Benefit Exclusions

- Duplication of x-rays.
- Temporary fillings, sedative fillings, tissue conditioning and acid etch.
- Core buildups including pins.
- Pulp capping.
- Surgical replacement of rubber dam, recalcification of perforation, preparation of canal for posts or dowels, and bleaching of discolored teeth.
- Periodontal appliances.
- Orthognathic surgery and surgery relating to accidental injury.
- Implants and transplantations.
- IV Sedation/Analgesia.
- Temporary services and appliances. There is not a separate allowance for a temporary service or appliance.
- Sealants.
- Crowns used in splints for periodontal conditions.
- Crown build-ups done in connection with individual crowns and abutments.
- Cosmetic Surgery or Treatment. You are not covered for cosmetic surgery or for cosmetic treatment unless otherwise medically necessary. Cosmetic surgery is covered only when the cosmetic surgery or treatment involves reconstructive surgery incidental to or following surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery arising out of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- Care Furnished Without Charge. You are not covered for services for which no charge is incurred.
- Treatment Not Conforming to Accepted Dental Standards. You are not covered for services that do not conform to accepted standards of dental practice. You are also not covered for services that are considered experimental in terms of generally accepted dental standards, unless recommended by an external appeal agent.
- Services Covered by Government. You are not covered for services to the extent that your service is covered under any law of any State or the United States. An example of this would be when your service is covered by Medicare or Workers' Compensation. Services provided under Medicaid do not apply.
- Services Through Your Employer or Welfare Fund. You are not covered for services rendered in a hospital, department or clinic run by your employer, labor union or welfare fund.
- No Fault Automobile Insurance. You are not covered for any service for which automobile no fault insurance benefits are recovered or recoverable.
- Services Rendered by Member of Immediate Family. You are not covered for services rendered by the Subscriber, the Subscriber's spouse, or a child, brother, sister or parent of the Subscriber or of the Subscriber's spouse.

- Workers' Compensation. You are not covered for care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. GHI will not make payment even if you do not claim benefits you are entitled to receive under the Workers' Compensation Law. Payment will not be made even if you bring a lawsuit against the person who caused the injury or condition. Payment will not be made even if you receive money from that lawsuit and you have repaid the provider of services.
- Prohibited Referrals. You are not covered for clinical laboratory services, x-ray or imaging services or other services provided pursuant to a referral prohibited by Section 238-a(1) of the New York State Public Health Law. This law prohibits your dentist or physician from making referrals for such services to providers in which your dentist or physician, or a member of their immediate family, has a financial interest.
- Prescription Drugs and Medications.
- Injuries Due to War or an Act of War. Services rendered for any injury or condition due to war or any act of war, whether declared or undeclared, are not covered.
- TMJ Disorders. Services and appliances for the treatment of temporo-mandibular joint (TMJ) dysfunction syndrome are not covered.
- Behavioral Management. Costs incurred for behavioral management are not covered.
- Orthodontic Services.

Services GHI-Dental Does Not Cover

GHI Dental will not pay for the following: Orthodontic Services; temporary fillings; and replacement bridges and/or false teeth within three years from the date of the original installation of the appliances if GHI-Dental made payment toward the cost of the appliances.

Workers' Compensation cases and Veterans' Administration cases; cosmetic surgery or treatment, except for re-constructive surgery following an accident, disease or surgery to correct congenital defects.

All inquiries regarding dental services or a participant's eligibility for dental benefits, as well as the status of claims submitted, should be directed to Group Health Incorporated or the Welfare Fund Office. These offices are your only authorized source for this information.

How to File a Claim or Appeal

For instructions on how to file a Dental claim, and how to appeal a denied (whether denied in whole or part) Dental claim, see the "Claims and Appeals Procedures" section.

ORTHODONTIC BENEFIT

Eligibility

A participant's unmarried dependent child (natural, adopted or placed for adoption) and/or unmarried dependent step-child who is enrolled in the Plan, is eligible to receive reimbursement of orthodontia service according to the Schedule of Orthodontia Benefits until attainment of age 23.

Covered Orthodontia Expenses

You are eligible for reimbursement for some of the expenses your dependent child incurs for certain orthodontic services and supplies that are determined by the Plan Administrator or its designee to be "Medically Necessary," but only to the extent that:

- the service or supply is listed in the Schedule of Orthodontia Benefits.
- all services and supplies listed in the Schedule of Orthodontia Benefits are reimbursed up to the benefit allowance for that service or supply.

Non-Eligible Orthodontic Expenses Explained

The Plan will not reimburse you for any expenses that are not Eligible Orthodontic Expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Orthodontic Expenses that exceed the benefit allowance. Habit-breaking devices, or adjustments to such devices, are not covered.

Coinsurance

The Plan reimburses you up to the Benefit Allowance of the Eligible Orthodontic Expenses, and you are responsible for paying the rest. The benefit allowance reimbursed by the Plan is shown in the Schedule of Orthodontia Benefits. The part you pay is called the Coinsurance.

Overall Lifetime Maximum for Orthodontia Benefits

The Overall Maximum Plan Benefits payable for Orthodontia services for any individual covered under this Plan and any previous dental expense plan or program provided to that individual is up to $2181. This amount may be less if all services are not provided or received within the various service time frames shown in the orthodontic benefit chart.

Payment of Orthodontia Benefits

This benefit is self-insured by the Welfare Fund and is a reimbursement benefit. This means that the Welfare Fund will directly pay benefits to you, the participant, as reimbursement. The Welfare Fund will reimburse for expenses incurred (and previously paid by you) for covered services performed or appliances received. In no event will benefits be paid in advance of receiving the treatment or appliance.

Services related to Orthodontia are provided over a period of many months, and are usually subject to a fixed charge for the entire program of treatment, usually payable in monthly installments. All services related to Orthodontia are considered to have been incurred on a month-to-month basis, and the Plan will pay benefits for services performed each month in an amount not to exceed the overall lifetime maximum for orthodontia benefits as long as eligibility for orthodontia benefits is maintained.

The number of months of orthodontic treatment received prior to the effective date of the program or the patient's eligibility for coverage will be deducted from the number of allowable active/passive months to be provided under the program. No benefit payment will be made for the appliance or any other service if such treatment was performed before the program's effective date or the patient's eligibility for coverage.

The number of consecutive months in which the allowed maximum of 20 active treatments may be received is 30 consecutive months from the start of treatment.

Schedule of Orthodontia Benefits

A chart outlining a description of the Plan's Orthodontia Benefits and the explanations of them appears on the following pages.

Coordination of Benefits (COB)

Coordination of Benefits rules are applied to all claims submitted under both the Group Health Inc. (GHI) dental insurance contract and the Welfare Fund self-insured Orthodontic Benefit. Review the Coordination of Benefits section

How to File a Claim or Appeal

For instructions on how to file an Orthodontia claim, and how to appeal a denied (whether denied in whole or part) Orthodontia claim, see the "Claims and Appeals Procedures" section.

The filing deadline is one year from the date of service or the date the appliance is received and postmarked no later than December 31st of the filing year.

SCHEDULE OF ORTHODONTIA BENEFITS

This chart notes what this Plan pays.

Benefit Description	Explanation and Limitations
• Necessary services related to an active course of Orthodontia treatment including diagnosis, evaluation and pre-care. • The initial installation of Orthodontic appliances for an active course of Orthodontia treatment. • Adjustment of active Orthodontia appliances. • This Orthodontia benefit is for nonsurgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. • Expenses related to Orthodontia will be covered only when the condition shown to the right has been satisfied.	• Orthodontia services **are subject to the Overall Lifetime Maximum Plan Benefits of up to $2181**. • Payment for Orthodontia benefits will not continue if treatment ceases for any reason. • Repair or replacement of Orthodontia appliances is **not covered**. • **Conditions Required for Coverage of Orthodontia:** • The patient must be under the age of 23 and an eligible covered dependent child of the participant.
• Exam; • Study Model; • X-rays; • Diagnosis; • Construction and insertion of appliance, and including all prophylactic appliances for tooth guidance used in either active or passive treatment.	• Benefit allowance of $300.
• Preliminary Appliance	• $75
• Active orthodontic treatment • Maximum number of active treatments that are eligible for reimbursement	• Maximum amount of reimbursement for each treatment is up to $75. • 20 treatments within a consecutive 30 month period. For example, your 16 year old daughter (unmarried, dependent child) has 20 active orthodontic treatment visits in a consecutive 30 month period. Each treatment is reimbursable up to $75. Therefore the maximum reimbursement amount would be $1500 ($75 per treatment x 20 treatments).
• Passive orthodontic treatment • Maximum number of passive treatments periods that are eligible for reimbursement	• Maximum amount of reimbursement for each treatment period is $102, per six months of treatment. • 3 consecutive 6-month passive treatment periods. For example, your 17 year old son (unmarried, dependent child) has 3 six-month treatment periods. Each six month treatment is reimbursable up to $102. Therefore the reimbursement amount would be $306 ($102 per six-months of treatment x 3 treatment periods).

TEMPOROMANDIBULAR JOINT DISORDER (TMJ) APPLIANCE BENEFIT

TMJ Appliance Benefit

Beginning July 1, 1996, a new reimbursement benefit was added to the self-insured benefits plan. This benefit covers the participant and his/her eligible dependents for the purchase of a palliative/prophylactic appliance prescribed for the diagnosed and specialized treatment of Temporomandibular Joint Disorder (TMJ). The Welfare Fund will reimburse for expenses incurred (and previously paid by you) for the appliance received. In no event will benefits be paid in advance of receiving the appliance.

The benefit reimburses the purchase of one appliance up to, but not to exceed, $1000. This is a one-time, lifetime benefit maximum. This TMJ appliance benefit does not cover nor include doctor office visits, dentist office visits, professional services or fees.

For information on your and or/your dependent's eligibility and beginning date of coverage, please refer to the Eligibility section of this booklet.

Coordination of Benefits (COB)

Coordination of Benefits rules are applied to all claims submitted under both the Group Health Inc. (GHI) dental insurance contract and the Welfare Fund self-insured TMJ Disorder Appliance Benefit. Review the Coordination of Benefits section described earlier in this booklet.

How to File a Claim or Appeal

For instructions on how to file a Temporomandibular Joint Disorder (TMJ) Appliance Benefit claim, and how to appeal a denied (whether denied in whole or part) TMJ Benefit claim, see the "Claims and Appeals Procedures" section.

The Welfare Fund will reimburse for expenses incurred (and previously paid by you) for the appliance received. In no event will benefits be paid in advance of receiving the appliance.

The filing deadline is one year from the date of service or the date the appliance is received and postmarked no later than December 31st of the filing year.

PRESCRIPTION DRUG BENEFITS

The Day Care Council-Local 205, DC 1707 Welfare Fund provides you and your eligible dependents with prescription drug benefits under a service contract held with Medco Health and its affiliates: Medco® for retail drugs and Medco By Mail. When you use a pharmacy within the Medco® network, you will be charged the co-pays identified below. If you go to a pharmacy that is not participating in the Medco® network, you will have to make a higher out-of-pocket payment than if you use a participating pharmacy.

When You Go To A Participating Pharmacy

Your prescription identification card and your prescription are all you need to obtain prescription service at a participating pharmacy. When you present your identification card, your pharmacist will ask you to sign for the prescribed medication and pay the applicable co-payment. Medication obtained through the Medco® participating pharmacies is subject to the three level co-payment schedule below and the quantity dispensed is limited to a 21-day supply and only one (1) refill.

- $10.00 co-pay for each generic prescription.
- $15.00 co-pay for each brand name medication when the medication has no generic equivalent available.
- $25.00 co-pay for each brand name medication when the medication has a generic equivalent available.

Covered Prescription Drugs:

Regardless of whether you receive services from a participating or non-participating pharmacy, the following prescription drugs are covered, unless listed as an exclusion at the end of this section:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications
- Oral Contraceptives
- Insulin on Prescription Only
- Betaseron (30 day supply)
- Depo-Provera Contraceptive

Quantity Per Copay:

Medication obtained through the network of participating pharmacies is limited to a 21-day supply and only one (1) refill (if prescribed) except for the following prescription drugs:

- Viagra, for males only, age 18 and over, limited to a 21-day supply or 8 units, whichever is less per claim.
- Relenza is limited to a 5-day supply or 1 inhaler/20 units whichever is less per claim.
- Tamiflu is limited to a 5-day supply or 10 capsules whichever is less per claim.

When You Go To A Non-Participating Pharmacy

If you wish to obtain prescription drugs at a non-participating pharmacy, you will have to pay the charge, then complete a reimbursement claim form to receive reimbursement.

You will be reimbursed directly up to the maximum allowable cost of the prescription, less a co-payment. The maximum allowable cost may, in some cases, be less than the actual charge you paid for the prescription.

How To File a Claim or Appeal

For instructions on how to file a prescription drug reimbursement claim, and how to appeal a denied (whether denied in whole or part) a prescription drug claim, see the “Claims and Appeals Procedures” section.

When You Use the Mail Order Delivery Service:

The benefit program has been expanded to include a mail-order prescription service for both the participants' convenience and savings on co-payment charges, especially when you and/or a dependent take prescription medication on an ongoing basis. In addition you may obtain up to a 90-day supply and obtain refills as prescribed by your doctor.

- $10.00 co-pay for each generic prescription.
- $15.00 co-pay for each brand name medication when the medication has no generic equivalent available.
- $25.00 co-pay for each brand name medication when the medication has a generic equivalent available.

RETIREES

Please refer to the Retiree Benefits Section of this booklet for information on the annual deductible.

Covered Prescription Drugs:

The following prescription drugs are covered by the home delivery service, unless listed as an exclusion at the end of this section:

- Federal legend drugs
- State restricted drugs
- Compounded medications
- Oral contraceptives
- Insulin on prescription only

Exclusions:

Regardless of whether you receive service from a participating or non-participating pharmacy or the mail order service, you are not covered for the following:

- Non-federal legend drugs.
- Diaphragms, contraceptive jellies, creams, foams or devices.
- Therapeutic devices or appliances.
- Drugs which primary purpose is to stimulate hair growth (Rogaine, Propecia) or for cosmetic purpose only (Renova).
- Drugs labeled "caution-limited by federal law to investigational use," or experimental drugs even though a charge is made to the participant.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant.
- Medication which is to be taken or administered to an individual, in whole or in part, while he/she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

Benefit Maximum

The annual prescription benefit maximum is $12,500 per individual. The combined total of prescription costs charged to the Welfare Fund for prescription drugs received by a covered individual from both retail pharmacies and the home delivery service is considered in determining whether the annual benefit maximum has been reached. The year is defined as a calendar year, January through December. Medco® will send a notice informing you when you have exhausted or used 80 percent of your annual benefit.

If you have any questions regarding your program, please call Member Services at 1-800-711-0917.

PRESCRIPTION DRUG BENEFIT QUICK REFERENCE

Pharmacist has questions?

If your pharmacist has any questions regarding this program, please have him/her contact Member Services at 1-800-711-0917.

You have questions? Or need to locate a participating pharmacy in your area?

If you have any difficulty using this benefit program, contact the Fund Office immediately at (212) 925-0005. You may also contact Member Services at 1-800-711-0917.

If you are unable to locate a pharmacy in your area that is a member of the Paid Prescription network, contact the above member services telephone number. They will furnish you with the name and address of the member pharmacies nearest you.

Refilling Prescriptions through the Home Delivery Service?

To refill by phone, call 1-800-4REFILL (1-800-473-3455) for the automated refill system.

Lost Prescription Identification Card?

Should your card be lost or stolen, report it to the Welfare Fund Office immediately. Your card can be replaced for a $3.00 fee. Make your check or money order payable to DCC, Local 205-D.C. 1707 W.F. Be sure to include your social security number on the face of the check or money order. A receipt will be mailed to you and the Fund Office will place the order to have the replacement card issued. You should expect to receive your replacement card by mail in approximately two weeks. A request for the replacement of an identification card can only be honored once every 12 months regardless of the reason for the request.

OPTICAL BENEFIT

Overview of the Optical Benefit

Optical benefits are offered through the Eyeglass Voucher Program or from the Optical Reimbursement Program. The Optical Benefit is available once every 12 months from the issue date of the last voucher or from the last reimbursement service date. The benefit is available to you and your eligible dependents. You may obtain the benefit by using either the voucher program or reimbursement program as described.

Eyeglass Voucher Program

Prescribed eyeglasses and related services may be obtained, at no cost, through one of the following Optical Service companies:

1. Comprehensive Professional Services
2. General Vision Services
3. Vision Screening

Through these companies, the following services are available to an active participant, spouse and eligible dependent children and a retired participant and spouse, once every 12 months:

- Eye examination and glaucoma testing.
- Single vision or bifocal lens, as required.
- Varied frame selection from specified groups.

In addition to these basic services, the companies will also provide:

- Filling of prescriptions written by an Ophthalmologist, even though the services of the Ophthalmologist are not covered by this benefit.
- Unlimited fitting and adjustment, as required.

Obtaining Benefits Under the Eyeglass Voucher Program

1. Call the Welfare Fund Office and request an eyeglass voucher. One can be issued for you and one for each eligible dependent. The voucher(s) will not be mailed and must be picked up at the Fund Office.
2. Upon receiving the eyeglass voucher(s), present it at any one of the optical service locations, which is most convenient for you. The voucher requires a counter-signature, which must be entered at the location where service is rendered.
3. You must use this voucher within 30 days from the date issued. If you wait until after the 30-day period, you must return the voucher to the Fund Office to receive a currently valid one. If the voucher is lost, stolen or destroyed, a six- (6) month (180 day) waiting period is imposed before another voucher can be issued again.

   If you do not use the original voucher and a second voucher is issued, and you do not use the second voucher within the 30 day period, a third voucher cannot be issued. You will have to wait 12 months to be eligible for another voucher. During the waiting period you may use the reimbursement benefit in lieu of the voucher.

Optical Reimbursement Program

The Optical Benefit is also available if you want to use your own Optometrist or Optician, instead of the voucher program. The voucher will only be updated once. The benefit will be paid based upon the schedule in effect at the time services are performed. You will be reimbursed for optical service expenses based upon the schedule below:

Maximum Reimbursement Schedule

- $100.00—-complete optical service includes exam, frame and single vision, or bifocal lenses.
- $100.00—-prescribed contact lenses, fittings and exam.
- $100.00—-cataract lenses, exam and frame.

If you do not use the complete services as shown above, reimbursement for partial optical services is available and will be based on the schedule indicated below. Please note that reimbursement is available only **once in a 12-month period** whether you use the complete or partial services. It will not exceed the scheduled amount shown for the service received and will not exceed the total maximum reimbursement amount of $100.

Partial Services Schedule

- $60.00—-pair of single vision lenses only.
- $70.00—-pair of bifocal or cataract lenses only.
- $15.00—-eye examination only.
- $25.00—-frame only.

How To File a Claim or Appeal

For instructions on how to file an Optical Reimbursement Benefit claim, and how to appeal a denied (whether denied in whole or part) Optical Reimbursement Benefit claim, see the "Claims and Appeals Procedures" section.

Definition Of Terms Used In This Optical Benefit

- A **vision exam** includes an examination by an optometrist and an eye refraction including case history, exam for pathological abnormalities of the eyes and lids, ranges of clear single vision, and balance and coordination of muscles for far-seeing and near-seeing and special working distances.
- **Dispensing optician** means a person qualified to manufacture and sell eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry.
- **Ophthalmologist** is a physician licensed to practice ophthalmology.

Optical Benefit Limitations

You and your eligible dependents are entitled to a voucher or reimbursement only once in a twelve (12) month period from the date of service, regardless of the type of service you receive (full or partial). So please be sure to maximize your benefit by getting all your needed care at one time. The 12 months referred to in this section is not a calendar year (January to December). Rather, the year is measured as 12 months from the service date of your last voucher or reimbursement check.

Optical Benefit Exclusions

The Optical Benefit is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Optical Benefit will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras, such as:

1. Oversized lenses (larger than 61mm), coated lenses, tinted lenses (addition of substance to produce a color such as pink or green, etc), photochromic lenses (changes color with intensity of sunlight), sunglasses (plain or prescription), laminated lenses, plano (non-prescription/no refractive power) lenses or orthokeratology lenses for reshaping the cornea of the eye to improve vision.
2. Vision services and supplies that cost more than the Optical Benefit's allowance as noted in the Reimbursement Schedule.
3. Orthoptics (vision training to improve the visual perception and coordination of the two eyes), subnormal vision aids and any associated supplemental testing.
4. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
5. Glasses secured when there is no prescription.
6. Two pair of lenses or eyeglasses in lieu of bifocals.
7. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK).
8. Services or materials provided as a result of any Workers' Compensation Law, or similar occupational health legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.
9. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
10. Treatment received from a medical department maintained by an employer, a mutual benefit association, a labor union, a trustee or a similar type group.
11. Experimental and/or investigational treatment or procedure.
12. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
13. Benefits incurred beyond the termination date of the Plan, unless COBRA coverage is in place.

Coordination of Benefits (COB)

Coordination of benefits (COB) rules are applicable to all participant and eligible dependent claims submitted for processing under the Plan. See COB section for more details.

ADDITIONAL SUPPLEMENTAL WELFARE BENEFITS

Additional Welfare Fund benefits were implemented and designed to significantly supplement the basic medical insurance, for you and your eligible dependents. All of these benefits are self-insured, which means that the Welfare Fund, not an insurance company, provides these benefits directly to you and your dependents. The benefits include:

Professional Nursing

The benefit amount is the cost of private duty nursing care, up to a maximum of $3000 per individual, per calendar year. Nursing care must be ordered by a physician and provided by a Registered Nurse (R.N.) either in the hospital or in the home. If an R.N. is not available, a Licensed Practical Nurse (L.P.N.) may be substituted, at the doctor's request.

Ambulance/Ambulettte

The benefit amount payable will not exceed the reasonable per trip charge, in a service area, for ambulance and/or ambulette services. The maximum calendar year-benefit is $3000 per individual. The benefit payment will be calculated based upon the total amount of charges paid, less benefits provided by GHI Medical or HIP/HMO or any other group health plan. The allowable service covers private ambulance or ambulette travel to and from a hospital, rehabilitation or physical therapy facility.

Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances

The benefit amount payable will be up to a $3000 maximum benefit, per individual, per calendar year. A schedule of approved equipment/appliances is used to determine coverage and/or limitations. A participant should call the Fund Office prior to any purchase to inquire and verify that an item is covered. Examples of allowable and covered items include but are not limited to:

- The purchase or repair of artificial eyes and limbs, hearing aids, diathermy equipment, surgical belts and surgical hose, braces and other orthopedic appliances;
- The purchase or rental of a hospital bed, walker, wheelchair, crutches, oxygen (and the equipment for its administration), standard or portable nebulizer for the treatment of severe asthma, emphysema and Apnea monitors prescribed for the treatment of sleep disorders;
- The purchase and/or repair of medically prescribed orthotics, custom molded shoes, box-toe shoes, and orthopedic alterations to shoes prescribed to correct problems and conditions of the feet. Orthopedic shoes are limited to one (1) pair per individual, per calendar year; shoes prescribed for comfort are not considered orthopedic in nature and are not covered.
- Breast prosthesis and one (1) brassiere (less benefits provided by GHI Medical, HIP/HMO or any other entity which is primary under New York State law).

Principal exclusions of the Prescribed Durable Medical Equipment/Appliance Benefit are health and medical items which can be legally dispensed over-the-counter without a doctor's prescription, eyeglasses, splints and casts, mattresses, homemaker services, workers compensation and Veterans Administration cases. The Welfare Fund uses a schedule to determine whether or not the item is reimbursable under the Plan. This schedule is available upon request and free of charge. See the exclusions related to Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances in the Exclusions section of this booklet.

All benefit payments are made for the reimbursement of expenses, previously paid by the covered participant, for services or items which are not covered by or are not available under the basic medical insurance programs (GHI/Blue Cross or HIP/HMO) or any other plans of a contributing Employer covering the participant and/or eligible dependent(s).

How To File a Claim or Appeal

For instructions on how to file an Additional Supplemental Welfare Benefit claim, and how to appeal a denied (whether denied in whole or part) Additional Supplemental Welfare Benefit Claim, see the "Claims and Appeals Procedures" section.

Coordination of Benefits (COB)

Coordination of benefit (COB) rules are applicable to all participants and eligible dependent claims submitted for processing. See the COB section for more details.

SUPPLEMENTAL WELFARE BENEFITS PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered by the Supplemental Welfare Benefits Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Supplemental Welfare Benefits program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically-related plan exclusion.

General Exclusions

(applicable to all Supplemental Welfare Benefits and supplies)

1. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls and/or photocopying fees.
2. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, Annual Maximum Plan Benefits, or Overall ("Lifetime") Maximum Plan Benefits as described in this document.
3. **Expenses for Air TransportationAmbulance Services:** Expenses incurred for or related to air transportation ambulance services.
4. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.
5. **Experimental and/or Investigational Services:** Expenses for any services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions section of this document.
6. **Government-Provided Services (Tricare/CHAMPUS, VA, etc.):** Expenses for services when benefits for them are provided to the Covered Individual under any plan or program (including, without limitation, Tricare/CHAMPUS and Veterans programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.
7. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
8. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions section of this document.
9. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.
10. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without

cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

11. **No Physician Prescription:** Expenses for services rendered or supplies provided that are not prescribed by a Physician or Podiatrist.
12. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual.
13. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. [This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law have been waived or qualified.]
14. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
15. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
16. **Internet/Virtual Office Visit:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, physician-patient web service or physician-patient e-mail service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.
17. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
18. **Operation of a Vehicle Under Influence of Alcohol or Drugs:** As determined by the Plan Administrator or its designee, expenses incurred by any covered individual for injuries caused in a motor vehicle accident if the covered individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the injuries arise as a result of a physical or mental health condition. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the motor vehicle accident.

Exclusions Applicable to Specific Services and Supplies

A. **Prosthetic, Orthopedic, and Prescribed Durable Medical Equipment Appliances Exclusions**

1. Expenses for any items that are not ordered by a physician and are not:
   - Corrective Appliances,
   - Orthotic Devices,
   - Prosthetic Appliances, or
   - Durable Medical Equipment as each of those terms is defined in the Definitions section of this document.
2. Expenses for any items, devices, equipment, material and/or supplies that are:
   - convenience and/or comfort,
   - hygenic equipment,
   - educational/teaching,
   - environment control,
   - exercise equipment,

- self-help devices,
- institutional and/or physician equipment,
- non-reusable and disposable,

3. Expenses for air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
4. Expenses for **replacement of lost, missing, or stolen, duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
5. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment.
6. Expenses for occupational therapy (orthotic) supplies and devices needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing.
7. Expenses for nondurable supplies, except as payable under Nondurable Supplies.
8. Expenses for any items, devices, equipment, material and/or supplies that can be legally dispensed over the counter without a doctor's prescription.

B. **Cosmetic Services Exclusions**

1. Services or appliances to improve or preserve physical appearance, but not physical function. Cosmetic Services or appliances includes, but is not limited to breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Plan does cover Medically Necessary Reconstructive Services under DME.

C. **Custodial Care Exclusions**

1. Expenses for Custodial Care as defined in the Definitions section of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care and/or sitter/companion service.
2. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are not considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are not covered, even if they are Medically Necessary.

D. **Drugs, Medicines and Nutrition Exclusions**

1. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e. are used "off-label") or are Experimental and/or Investigational as defined in the Definitions section of this document.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin.
3. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), and except for prenatal vitamins or minerals requiring a prescription.
4. Medical Foods,
5. Naturopathic, naprapathic or homeopathic services and substances.
6. Drugs, medicines or devices for:
   - Diaphragms, contraceptive jellies, creams, foams or devices.
   - Therapeutic devices or appliances.
   - Drugs which primary purpose is to stimulate hair growth (Rogaine, Propecia) or for cosmetic purpose only (Renova).
   - Drugs labeled "caution-limited by federal law to investigational use," or experimental drugs even though a charge is made to the participant.

- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant.
- Medication which is to be taken or administered to an individual, in whole or in part, while he/she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- diabetic supplies, including lancets, test-strips, testape, supplies for blood glucose testing devices, alcohol swabs, which are covered under New York State mandate by your medical insurance provider.

7. Any prescription drug or medicine not provided by the Plan's prescription drug program.

E. **Durable Medical Equipment Exclusions**
See the Exclusions related to Prosthetic, Orthopedic, and Prescribed Durable Medical Equipment Appliances.

F. **Hearing Care Exclusions**
1. Expenses for and related to the purchase, servicing, fitting and/or repair of implantable hearing devices such as cochlear implants.
2. Special education and associated costs in conjunction with sign language education for a patient or family members.

G. **Optical Benefit Exclusions**
1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies except as provided by the Optical Benefit.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

H. **Professional Nursing Exclusions**
1. Expenses for any Professional Nursing services other than the cost of Private Duty Nursing care up to the Plan's maximum allowed charge.
2. Expenses under Professional Nursing Care services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, and when custodial care is provided by Home Health aides.

J. **For Nondurable supplies Exclusions**
See exclusions related to Prosthetic, Orthopedic, and Prescribed Durable Medical Equipment Appliances.

I. **Smoking Cessation or Tobacco Withdrawal Exclusions**
1. Expenses for tobacco/smoking cessation products such as nicotine gum or patches, or other services or programs.

SURVIVOR BENEFIT

If you die from any cause while you are an actively employed participant, a Survivor benefit of $10,000 will be paid to your beneficiary in a lump sum. This benefit is self-funded. If more than one beneficiary is designated, the benefits will be shared equally by the named beneficiaries.

A Designation of Beneficiary form must be on file in the Fund Office.

Your Beneficiary

Participants must choose, and designate by means of the Designation of Beneficiary Form, the person(s) who is (are) to receive the benefits upon his/her death. If married, the spouse must be designated as a beneficiary, unless a waiver of benefit is signed by the spouse and notarized. Other designated beneficiaries may be anyone regardless of relationship to the participant. The Designation of Beneficiary Form is available by calling the Welfare Fund Office.

- A minor child can be designated beneficiary as long as a legal guardian has been assigned and noted on the Beneficiary Form.
- A contingent beneficiary will be eligible only in the event of the death of the designated beneficiary(ies).
- If a beneficiary has not been designated, the benefit is payable to the deceased participant's estate.

Please Note: Federal legislation mandates that all self-funded or insured survivor benefit payments are subject to income tax, payable by the beneficiary(ies), for deaths occurring on or after August 1996.

How To File A Claim Or Appeal

For instructions on how to file a Survivor Benefit claim, and how to appeal a denied (whether denied in whole or part) Survivor Benefit claim, see the "Claims and Appeals Procedures" section

CONTINUATION OF SUPPLEMENTAL WELFARE FUND COVERAGE WHILE DISABLED

Continuation of Welfare Fund Coverage is available for disabled participants and dependents. The disability must be due to illness, injury or complications of pregnancy or childbirth and the Fund must be notified within 30 days of the onset of disability.

This means that the benefits described in this booklet, except for the basic GHI Medical, Empire Blue Cross or HIP/HMO plans (which are not Welfare Fund benefits), may be continued for up to a period of six- (6) months, provided the participant is approved for disability leave and the Fund Office is notified within 30 days of the participant's last day of work due to the approved disability leave.

In order to be eligible for continuation of Supplemental Welfare Fund Coverage while you are disabled, you must have applied for and be receiving New York State Disability benefit payments or be receiving payments from your Employer's short term disability insurance company.

The short term disability Insurance carrier may approve the leave for up to three (3) months during which period the day care center will continue to make welfare fund contributions for your welfare fund benefits.

If you are unable to return to work within the three (3) month period but no more than six (6) months, you must apply for an extension of your disability leave. Please contact your physician, day care center and Disability Insurance carrier for information and the documentation needed in order to apply for the extension.

Once the extension of Disability has been approved by the Disability Insurance carrier, you must notify the Fund office by submitting copies of the extension notification (approving your leave for months four (4) up to six (6). Once the notice is reviewed by the Fund office you will be notified if your fund benefits have been

extended for the additional 3 months (not to exceed a total of six (6) months disability leave from your last day worked.

If the employee is unable to return to work within the six- (6) month period, he/she will be notified of the date that his/her Welfare Fund benefits terminate. At the time benefits end for the participant, they also end for the dependent(s). You and your dependents may be eligible for continuation of coverage under COBRA, see the Continuation of Coverage section of this booklet for more information.

To Maintain Benefits While Disabled, **You Must:**

1. Mail a copy of your completed disability claim form to the Fund Office as soon as possible. The copy must include the doctor's signed statement attesting to the diagnosis of illness, injury or pregnancy and the date that you are able to return to work. The Fund Office will contact you and your Center periodically to verify your continued disability status.

2. Submit proof of your certified disabled status to the Fund Office, preferably on a monthly basis. The only proof acceptable is:
   a. Copy of your disability income benefit check(s) and/or check stub(s)
   b. Other verifiable information concerning your Disability claim such as your Disability Claim Number and the name of the Disability Insurance Carrier.

Unless this proof of disability is on file in the Fund Office, your eligibility for benefits will be handled as if you terminated employment. Benefits will then end as of the last day of the month in which you last worked at the Day Care Center. Upon proof being received (within thirty (30) days of the onset of disability), benefits may be reinstated for that period of time for which the disability carrier has paid benefits and/or verified disability.

If your disability notification is received later than thirty (30) days from the occurrence, you may experience a loss of benefits and a break in your coverage. The enrollment for disability benefits will be delayed and the effective date will be based on the date that the notification was received at the Welfare Fund office.

DISABILITY INCOME SUPPLEMENT FOR THE PARTICIPANT

This benefit is designed to supplement the participant's Center provided disability insurance benefit payments beginning on the 14th week of a covered non-job-related illness or accident. A participant must apply for this income supplement within 30 days of the fourteenth (14) week of approved disability leave to be eligible for the benefit. Failure to file within the required time will result in the loss/denial of the benefit.

Schedule of Disability Income Supplement Benefits

A. **Weekly Benefits**	$50 a week, payable for the 14th week through the 26th week of the participant's approved and covered disability period.
B. **Maximum Benefit Duration**	14th week through the 26th week of approved and covered disability period.
C. **Waiting Periods**	1st week through and including 13th week of approved and covered disability.

Coverage

A. **When Weekly Benefits Are Payable:** The Plan will pay Supplemental Income Benefits while you are Totally Disabled. The determination of "Totally Disabled" is made by the Plan Administrator or designee and is subject to the following four conditions:
   1. You become Totally Disabled while you are covered for Short-Term Disability Benefits;
   2. You are and remain under the care of a Physician, [Chiropractor, Podiatrist or Psychologist] while you are Totally Disabled; and
   3. You are not engaged in any other occupation or employment for which you are or become

qualified by education, experience, or training.

4. You are in receipt of New York State Disability Benefits (or Disability Insurance Carrier) from the 1st week through the 26th week of covered disability.

B. **Definition of "Totally Disabled"**

For the purposes of the Disability Income Supplement Benefits, **"Totally Disabled"** means the inability of a covered employee to perform all the duties of his or her job with the Employer as a result of non-occupational illness or injury.

C. **Recurrence of Disability**

If you return to work and become Totally Disabled again from the same or a related cause within 4 weeks, the recurrent disability will be considered to be a continuation of the original Total Disability. Weekly Benefit payments will resume (if eligible), and your recurrent Total Disability will be subject to the Plan provisions in effect at the time your original Total Disability began.

The payment of the Disability Income Supplement will resume if your New York State Disability benefits restart and you are within weeks 14 through 26 of the disability period.

Payments of the Disability Income Supplement will not exceed 13 weeks for any one period of disability, nor may a participant receive more than 13 weeks of benefits during any 52 consecutive weeks, regardless of the number of periods of disability during this period.

The Disability Income Supplement Benefits are never paid for the first week of the onset of the disability up to and including the 13th week of continuous disability,

General Exclusions

No Weekly Benefits will be paid if your Total Disability is caused by:

1. **Cosmetic Surgery or Sex Change:** Cosmetic surgery or any sex change surgery or procedure.
2. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
3. **Occupational Illness or Injury:** An occupational (work-related) illness or injury.
4. **Operation of a Vehicle Under Influence of Alcohol or Drugs:** Expenses incurred by any Covered Individual for injuries caused in a motor vehicle accident if the Covered Individual was operating the vehicle and the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, that the Covered Individual:
   - had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred; or
   - was under the influence of drugs that are illegal in the jurisdiction in which the accident occurred.

   The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the motor vehicle accident.
5. **War or Similar Event:** Any injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Disability During Waiting Period and After Maximum Benefit Period

For each Period of Disability, no Weekly Benefits will be paid for:

1. the Waiting Period; or
2. more than the Maximum Benefit Period.

"Period of Disability" means any one continuous period of Total Disability that is due to one or more causes. Successive periods of Total Disability will be considered to be one continuous Period of Disability if:

- the periods of Total Disability are due to the same cause or a related cause and are not separated by 4 weeks of active work at your job; or
- the periods of Total Disability are due to different causes and are not separated by [one day] of active work at your job.

Proof of Disability

A. You must submit proof of a claim for Weekly Benefits. **See the Claims and Appeals Procedure section for information about How to File a Claim, Time Limit and Requirements for Filing Disability Income Supplement Benefit Claims, Discretionary Authority of the Plan and Its Designees, and the Review Procedure if Your Claim Is Denied.**

B. The Plan Administrator or its designee reserves the right to review the medical records of the Physician(s) and other Health Care Provider(s) who provide medical care and treatment to you during any period in which Weekly Benefits are being requested or paid.

C. The Plan Administrator or its designee reserves the right to have you examined, at the Plan's expense, by a Physician of its choice as often as may be reasonable during the period during which Weekly Benefits are being requested or paid.

When Payment of Weekly Benefits Starts

Payment of Weekly Benefits starts **after** the applicable Waiting Period has been completed, provided that the claim for the Disability Income Supplement benefit has been received within 30 days of the fourteenth (14) week of approved disability.

When Payment of Weekly Benefits Ends

Payment of Weekly Benefits ends at the **earlier** of:

1. the date on which you are no longer Totally Disabled; or
2. after 13 weeks of Weekly Benefits have been paid.

How To File a Claim or Appeal

For instructions on how to file a Disability Income Supplement Benefits claim, and how to appeal a denied (whether in whole or part) Disability Income Supplement Benefits claim, see the "Claims and Appeals Procedures" section.

CCIP Disability Program

CityWide Central Insurance Plan (CCIP) administers the Center-provided Disability Program. Inquiries concerning this programs should be made to CCIP at (212) 274-5769 or your day care center.

If you have any questions regarding any supplemental benefit program described in this section, please call the Welfare Fund Office at (212) 925-0005.

Blue Cross Participants

If you are enrolled in Empire Blue Cross for your hospital benefits, your coverage for hospital benefits will end after three months of Approved Disability Leave. There is no extension available. You will be eligible to continue hospital coverage under COBRA. Please see the section entitled "Continuation of Coverage" for details.

TUITION ASSISTANCE BENEFIT

Historical Background

The Welfare Fund provides a Tuition Assistance Benefit, which is available only to non-administrative employees of Group Day Care and Family Day Care Centers. The program offers reimbursement assistance toward the cost of tuition for job-related courses of study and for teachers enrolled in a Masters Degree program leading to permanent New York State certification.

Intention of the Benefit

The Tuition Assistance Benefit is intended to help eligible center workers further their education or advance their careers in the Day Care employment system.

- If you are a Cook, Helper or Janitor, this program can help you upgrade your skills and/or receive training to qualify for other Center position job titles covered under D.C. 1707, Local 205 Bargaining Agreement.
- If you are an Assistant Bookkeeper or Bookkeeper, this program can help you improve your record-keeping and accounting skills and/or receive training to qualify for a teaching position in daycare.
- If you are an Assistant Teacher, Teacher's Aide or non-certified Teacher, this program can help you attain the necessary degree to become a Certified Group Teacher in Early Childhood Education.
- If you are a Certified Group Teacher, this program can help you attain a Master's Degree in Early Childhood Education and New York State permanent certification.
- If you are working towards earning a high school diploma, this program can also be of help to you.

Who is Eligible?

Day Care Workers are eligible for payment of the Tuition Assistance Benefit after they have been covered by the Welfare Fund for ten-(10) consecutive months and payment is for an eligible course of study begun on or after their Welfare Fund enrollment date. This 10-month period may not include any period during which you are on a leave of absence due to illness, maternity/paternity or accident, even though your eligibility for Welfare Fund health benefits may have been continued, or wages paid by the Day Care Center. Neither dependent spouses nor children are eligible for benefits under this program.

How Much Will the Tuition Assistance Benefit Reimburse?

Reimbursement for college tuition expenses will be made according to the following guidelines:

- Reimbursement is for a maximum of 16 credits in a twelve-(12) month period.
- Undergraduate reimbursement is up to a maximum of a $105 per credit.
- Graduate reimbursement is up to a maximum of $185 per credit.
- Any scholarship, awards and/or grants are deducted from the allowable reimbursement amount.

Tuition expenses for non-college credit courses and business, vocational and technical schools will be reimbursed upon the completion of the course of training or certificate program, up to a maximum of $1,560 in a twelve-(12) month period.

The term "year" or "twelve-(12) month period" does not mean a calendar year. It means the twelve-(12) month period measured from the beginning of the first semester or course of study for which a benefit check has been issued.

If you stop working at the Day Care Center, for any reason, or become an administrative employee before completing the entire term, course, semester and/or certificate program, you lose eligibility for this benefit and are not entitled to reimbursement.

What Is Not Covered?

Reimbursement will **not** be made for registration fees, administrative fees, test fees, correspondence home study courses, travel expenses, books or supplies, etc.

Reimbursement will **not** be made for classes taken to satisfy elective requirements or classes required as part of a job-related degree program that are not directly related to a career in daycare and/or early childhood education.

Reimbursement will not be made for courses that are not job related or not related to a career in day care or not related to a job title under the D.C. 1707, Local 205 Bargaining Agreement.

Reimbursement will not be made for classes taken if you are enrolled in a Major or course of study that is not job related or not related to a career in day care or not related to a job title under the D.C. 1707, Local 205 Bargaining Agreement.

What Does the Tuition Assistance Benefit Cover?

Reimbursement of graduate and undergraduate tuition expenses will be made to an eligible participant for any **job-related** courses or Day Care career advancement courses taken at an accredited college or university. Advancement must be within the day care job titles covered under the D.C. 1707 Local 205 Bargaining Agreement.

Classes taken as an elective or required as part of a job-related degree program will not be covered unless the course is directly related to a career in daycare and/or early childhood education. This means that non-job-related courses will not be eligible for reimbursement even though the course may be required for the degree program.

Tuition expenses will also be reimbursed to an eligible participant taking vocational, technical or business courses or courses for obtaining a high school equivalency diploma. These courses must be taken at a school registered and licensed by the NYS Department of Education.

Tuition expenses related to Cornell University's "Union Women's Studies Program" are also eligible for tuition reimbursement. To be eligible for reimbursement, all such courses must be related to a career in Day Care employment job titles covered under the D.C. 1707 Local 205 Bargaining Agreement.

For additional information concerning courses offered at Cornell University School of Industrial and Labor Relations, contact:

Registrar
Cornell University School of Industrial &
Labor Relations
16 East 34th Street, 4th Floor
New York, New York 10016
Phone (212) 340-2826
Fax: (212) 340-2822

All courses (of study) must be **job-related**. Courses not clearly **job-related** will be submitted to a Committee of the Trustees for their review and subsequent approval or disapproval.

How Does the Tuition Assistance Benefit Work?

Tuition Reimbursement Claim Forms are available from the Fund Office. In order to receive reimbursement for tuition expenses, an eligible participant must:

- Submit proof of successful completion of the course of study (this means that you must pass the course). An incomplete grade for a course is considered a failing grade and the course is not eligible for reimbursement.
- Submit a bursar's or school's paid receipt for the course.
- Maintain employment in a contributing Day Care Center. (This means that you must be working in covered employment from the time the course begins, through and including the time the course ends).
- Have met the benefit's consecutive 10-month eligibility requirement.
- Be a non-administrative employee from the time the course begins, through and including the time the course ends.

The Claim filing deadline is one year from the start of the course or semester and postmarked no later than December 31st of the filing year.

Tuition Assistance Coordination of Benefits (COB)

The Welfare Fund will coordinate its benefits with any government educational grants (P.E.L.L./B.E.O.G., T.A.P., E.I.P. etc) and/or scholarships funded by the school or any other learning institution, company, union or agency, whether it be public or private, for which you are approved.

Benefits under this COB provision are calculated based upon the out-of-pocket tuition expense incurred by the covered participant. Out-of-pocket expense is the amount of expense remaining after other grants and/or scholarships have been paid, or approved for payment. When there is coordination of benefits, the out-of-pocket expense will be treated as if it were the actual tuition charge. This remaining balance will be divided by the number of credits taken to determine the cost per credit, up to the maximum number of credits per twelve-(12) month period.

Educational Incentive Program (EIP)

The State University of New York, Early Childhood Education and Training Program administers an Educational Incentive Program (EIP) funded by the New York State Office of Children and Family Services.

EIP awards grants to professionals engaged in credit-bearing courses and to those seeking acknowledged credentials within the child care profession. It is designed to provide scholarship money to help child-care providers and staff obtain the training and education they need to provide quality childcare.

These grants are available to members of this Welfare Fund. Since this Welfare Fund provides tuition reimbursement, each fund participant working in a classroom setting must apply for an **EIP Award** before filing a claim form for reimbursement from the Welfare Fund. Copies of the EIP award notification, denial, or deferral letter should be attached to the Welfare Fund Claim Form. We will not process your claim without it.

Award grants will reduce your out of pocket costs, as well as the Fund's reimbursement.

If an eligible fund participant does not apply for the EIP award, the amount of the award that would have been received had they applied will be deducted from the reimbursement. In other words, if you do not apply for the Educational Incentive Program, your claim will be treated as if you had applied for EIP and the amount of the EIP award you would have received will be deducted from your reimbursement.

Please note that EIP has a filing deadline. **If you do not file before December 31st of the year in which you take the course your application will not be considered and your tuition reimbursement claim will be reduced by the amount EIP would have paid you had you applied in time.**

Information, brochures, and applications may be requested by from:
SUNY, Early Childhood Education and Training Program at 1-800-295-9616 or www.tsg.suny.edu.

Student Loans

Since student loans are the liability of the borrower, they will not be recognized in the calculation of this benefit. In other words, benefits will be paid as if no student loan existed.

"Non-Credit" College Course

Non-credit college courses will be converted to equivalent credits for the purpose of calculating this benefit. This conversion will be based on the tuition charge for the course. This amount is then divided by the normal college credit charge. These equivalent credits will be charged toward your maximum credit allowance for a twelve-(12) month period.

Taxation of Tuition Assistance Benefits

As a result of the Taxpayer Relief Act of 1997, under the current Internal Revenue Code section 127 (a), employees can receive up to $5,250 per year of "educational assistance" tax-free, whether or not job-related.

GROUP LEGAL FUND SERVICES

The Group Legal Fund of the Day Care Council-Local 205, DC 1707 provides a Legal Services Plan, for the participant only, which enables him/her to obtain legal representation, at no cost.

Who Is Covered?

The Group Legal Fund's benefits are provided for the participant only.

When Do Benefits Begin?

A Day Care worker becomes eligible for Group Legal Fund benefits following twelve-(12) consecutive months of Welfare Fund participation.

Return From Leave

Employees who return to work from approved leaves of absence within the guidelines shown below will be eligible for legal services benefits on the **first of the month following the date of return.**

Maternity/ Paternity leave	18 months
Disability leave	6 Months
Workers Compensation leave	6 Months
Family & Medical Leave Act (FMLA) leave	12 Weeks

Please note, the effective date for benefits as stated above is based on the timely receipt of the enrollment card and required documents. Any delay in submitting the enrollment card to the Welfare Fund for processing will affect and delay the effective date for benefits. This means that whenever an enrollment card is received late (beyond 30 days from the date of hire or return to work), the eligibility for benefits will be based upon the date that the completed, signed, and Center-verified enrollment card (and required documents) is received at the Welfare Fund office.

How Are Services Provided?

The Board of Trustees of the Group Legal Fund has designated a law firm of highly qualified attorneys to be the only authorized provider of the legal service benefits to eligible participants covered under this Plan. The law firm is:

Gorlick, Kravitz and Listhaus, P.C.
17 State Street, 4th floor
New York, New York 10004
Tel. 212 269-2500
Fax. 212-269-2540

When you have a legal problem, you should first call the law firm's office to verify your eligibility for legal benefits and to set up an appointment. The law firm does not determine your eligibility, they merely confirm it. Any questions regarding your eligibility for legal services should be directed to the Group Legal Fund Office at (212) 925-0005.

What is Covered Under Legal Services?

The types of legal problems or matters for which legal counsel will be provided under the Group Legal Fund are limited to the following distinct case categories only.

General Domestic Relations

Child support
Visitation rights
Guardianship
Alimony
Contested and uncontested annulment or separation
Contested and uncontested divorce
Contested and uncontested adoption
Other family matters in family Court
Job-related child abuse allegations
Tenant vs. landlord matters
Wills and testaments
Powers of attorney
Living will

This benefit allows for limited legal consultation on "Other Types of Matters."

What Is Not Covered?

The Plan does not provide legal counsel for the following matters:

- Preparation of income tax forms or representation in tax matters,
- Real estate matters other than those concerning your principle residence,
- Class actions,
- Claims which can be handled in a local Small Claims Court,
- Cases which were pending before you became eligible for participation in this Plan and for which you retained legal counsel,
- Cases involving your business interests
- Job-related criminal cases
- Frivolous matters having no legal merit or involving harassment,
- Workers' Compensation cases,
- Criminal matters,
- Patent and copyright matters,
- Disputes involving employer, union, Plan or affiliated groups,
- Controversies, disputes or proceedings, the legal fees for which the Fund or the union is prohibited by law to defray,
- Cases which cannot be handled within a 50-mile radius of Columbus Circle in New York City,
- Payment of fines or penalties,
- Cases which involve unreasonable costs or time,
- Personal injury cases. However, if you are the plaintiff in a personal injury case, the Plan Attorney will handle such a matter for a fee equal to 25% of whatever is recovered. If nothing is recovered, you will not have to pay the fee.

How Does the Plan Work?

Each participant enrolled in the Group Legal Fund is entitled to a Plan year maximum of 50 hours and a lifetime limit of 100 hours of legal service time, at no cost. However, once these hours are used they are not renewable. In addition, there are a number of conditions that determine how this time can be used.

1. No more than 50 hours can be spent on any one type of case in a Plan year. The Plan year is July 1 through June 30.
2. Unused hours cannot be carried over from one year to the next.
3. Legal case matters may carry over from one Plan year to the next. However the hours involved will be charged as the work is done and will be subject to your available yearly and/or lifetime balance of hours.
4. If a participant's use of the Plan exceeds the stated yearly and/or lifetime maximum hours on a covered case type, he/she may wish to retain the Plan attorney and to pay for additional hours at an hourly rate agreed upon with the attorneys or may prefer to retain another attorney to handle the pending matter. If the participant chooses the latter option, the Plan attorney will seek to formally withdraw from the case if the relevant administrative law and ethical considerations allows him/her to do so. The Plan attorney will cooperate with your new attorney to ensure a smooth transition.

Whenever possible, the Plan Attorney will let you know in advance approximately how many hours are necessary to handle your legal matter and/or the balance available in your bank of hours as of the latest billing record posted to your participant file in the Group Legal Fund.

You should be aware that legal case matters often take longer to be resolved than you might expect. To make sure that your expectations are realistic for the type of case you have, discuss them with your attorney.

Benefit Limitations

The total lifetime benefit maximum is 100 hours, to be used as follows:

- Up to 50 hours in any Plan year (July 1- June 30).
- Consultations on "other types of matters," other than General Domestic Relations are limited in any plan year to two (2) consultations and a total of five (5) service hours.

The hours are not renewable. The Plan covers the hourly cost of the attorney's and/or Para-legal's time but not the court costs or fees related to the handling of legal matters. Once the lifetime maximum is used, it cannot be renewed.

When Do Benefits End?

Eligibility for legal service benefits ends on the **last day of the month in which the employee stops working** at the Day Care Center.

However, legal matters already being handled by the Legal Fund attorneys at the time the participant stopped working will continue to be handled and legal service benefits will be paid for up to six-(6) months from the date eligibility ends or until the balance of legal benefit hours have been used up, whichever comes first. Beyond this date or benefit hour limit, you will not receive benefits under this Plan and if you want the Legal Fund attorneys to continue to handle the case as a private matter, you must pay the cost of the legal services at rates agreed upon by you and the attorney.

Situations You May Not Have Thought Of:

What if other coverage is available to you?
Depending on the nature of your legal problem, you may be eligible for free legal assistance from an insurance company, a government agency program, your employer, or another party. If you are eligible for such assistance, the Plan provides only excess coverage. It does not duplicate the legal services you may be eligible for or have available from other sources.

What if you decide to appeal a legal decision?
The Plan will not provide benefits.

What about fines or penalties?
No coverage is provided for the payment of any fines, penalties, judgments or other money awards. Such payment is your responsibility.

What about court fees or filing charges?
Court fees and/or filing charges are not covered by the Group Legal Fund and are your responsibility.

What if the court awards attorney fees as part of a settlement?
If you are awarded the fees and costs of an attorney as part of a court settlement, the Fund shall be repaid to the extent that it paid these fees and costs.

Are there any fees for incidentals such as postage or carfare that are incurred by the Legal Fund providers?
You will be charged a non-refundable fee of $15.00 by the legal provider for these incidentals per legal case or legal matter opened.

What if you're involved in a legal dispute with another covered participant?
If you and another employee covered by this Plan are involved in a legal action against each other, the Plan will offer legal service to the participant with the most seniority in the Funds (Welfare and Group Legal). Only that eligible participant will be able to use the Plan attorney provided there is no conflict of interest on the part of the Plan attorney.

How are hours used calculated?
Any and all contact with the Group Legal Fund's attorneys, paralegals and support staff, as well as any time spent or efforts made on the participant's behalf by the Group Legal Fund's attorneys and staff, are used to calculate the hours used.

Taxation of Group Legal Services
Under section 120 of the Internal Revenue Code, the Group Legal Fund is required to report to each Day Care Center (employer), at the end of each calendar year, the value of all legal service benefits paid on behalf of its employees and covered participants, as personal income. This means that you and your Center employer will receive a notification from the Legal Fund advising you of the dollar amount of legal service benefits that you received during that calendar year. It is the Day Care Center's and your responsibility to report the amount as income and pay the applicable withholding taxes due, if any.

RETIREE SUPPLEMENTAL HEALTH AND WELFARE BENEFITS PROGRAM

Who is Eligible?

Upon retiring from covered employment at a participating Group Day Care Center or Family Day Care Center, a covered participant and spouse may be eligible for Retiree Supplemental Health and Welfare Benefits.

To be eligible, a participant must:

1. Have retired from active employment at a contributing day care center
2. Have reached age 62 or older
3. Have a minimum of five (5) years of enrollment in the Welfare Fund at the time of retirement
4. Have been covered under the Welfare Fund benefits plan for 48 of the 60 months immediately preceding retirement, and
5. Receive pension benefits from either the Cultural Institutions Retirement System (CIRS) or the Social Security Administration.

Early Retirement Eligibility

A participant under age 62 (early retirement) is also eligible if she/he meets specific age and years of Welfare Fund enrollment requirements, at the time of retirement. To be eligible for early retirement, a participant must :

1. Have been covered under the Welfare Fund benefits plan for 48 of the 60 months immediately preceding retirement, and
2. Receive pension benefits from either the Cultural Institutions Retirement System (CIRS) or the Social Security Administration.
3. Must have the number of years of Welfare Fund enrollment required, as per the following:

Age of Participant	**Required Years of Welfare Fund Enrollment**
Ages 60-61	10 years
Ages 58-59	15 years
Ages 55-57	20 years
Ages 52-54	25 years

Disability Retirement Eligibility

A participant, regardless of age, who becomes permanently and totally disabled as determined by the Social Security Administration is eligible to enroll in and receive the Fund's retiree supplemental benefits if:

- The participant has a minimum of ten (10) years of participation in the Welfare Fund,
- The participant is eligible to receive either CIRS Disability Retirement Pension Benefits or Social Security Disability Benefits.

Spouse Eligibility

In order to be eligible for coverage, a spouse must be enrolled at least 30 days prior to the participant's retirement. Dependent spouses are not eligible for retiree benefits nor added to retiree coverage after the participant has retired. When benefits end for the retired participant, they also end for the spouse, who may elect continuation of coverage under COBRA.

Dependent Children Eligibility

Dependent children are not eligible for coverage under the Retiree Supplemental Health and Welfare Benefits. When benefits end for the dependent children, they may elect continuation of coverage under COBRA.

Definition of Retirement

Retirement is defined as having been actively employed, as a permanent full-time employee, at a contributing day care center and retiring from that active employment. A former employee is not eligible for Retiree Supplemental Health Benefits if she/he left active day care center employment for any reason other than retirement (including disability retirement as defined by the Social Security Administration).

If You Return to Work

If you return to work in a unionized day care center or within the day care system, your retiree benefits will be suspended until the time that you again stop working in the day care system. Please notify the Welfare Fund Office if you intend to or have returned to work.

If You Change Your Address

You must notify the Welfare Fund Office of any change of address. Without the correct address, we cannot ensure that you will receive notices and/or correspondence regarding your Retiree Benefits.

Retiree Supplemental Health Benefits

Once you are enrolled in the program as a retiree, you and your spouse will be eligible for the following benefits:

- Prescription Drug Benefit
- Optical Benefit, once every 12 months

The benefit description and procedures to obtain benefit services are the same as those benefits detailed earlier in this booklet with the exception of Prescription Drug benefits which have a $100 annual deductible per person. The retail and Home Delivery Pharmacy Service co-payments are subject to a combined $100 deductible based on a twelve-(12) month calendar year benefit period. In order to receive credit toward your deductible, please make sure that you present your Medco Health prescription identification card to the participating retail pharmacy.

The following benefits are for the retiree only:

- Dental Benefit (See the GHI regular dental services section)
- Health Insurance Allowance.
- Survivor Benefit.

How To Enroll

Call the Welfare Fund at 212 925-0005 to verify that you satisfy the eligibility requirements and to request an enrollment form for the Retiree Supplemental Health Benefits program at least three months prior to your retirement date.

Enrollment Application Deadline

An eligible participant must apply for Welfare Fund Retiree Supplemental Health Benefits within eighteen (18) months from their last day of work due to retirement or disability retirement in order to be eligible under the plan. Supplemental Retiree Health Benefits will not be available if the application and required supporting documentation is received past the eighteen- (18) month deadline.

The effective date for enrollment in the Retiree Supplemental Health Benefits program will be determined based on the date of receipt of the required notification and documentation. If the application is received within 90 days of the last day worked, the effective date for Retiree Supplemental Health Benefits will be retroactive to the last day worked. If the application is received after 90 days from the last day worked, the Retiree Supplemental Health Benefits will become effective the first day of the month following receipt of the completed application and all required and requested documents.

Effective Date of Coverage

In the majority of cases, the effective date for Retiree Benefits coincides with the date that pension benefits, administered through the Cultural Institutions Retirement System (CIRS), become effective or the month following the end of eligibility for active participant coverage under the Welfare Fund, whichever comes first.

Health Insurance Allowance

A hospital and/or medical insurance premium allowance is also available for retired participants who meet the Retiree Supplemental Health Benefits Program eligibility requirements and are also under age 65. This program is designed to provide a bridge between the years that a participant retires and when he /she becomes eligible to be covered under the Medicare Part A hospital and Part B medical insurance programs.

Who is eligible
The Retiree ONLY is eligible for the Health Insurance Allowance.

Allowance Schedule for Reimbursement
The program will pay an allowance toward the cost of a participant's hospital and medical insurance premium. The allowance will be paid quarterly (every three- (3) months) as reimbursement for the participant's previously paid expenses. The maximum amount will be based upon the monthly premium for individual coverage under the direct payment HIP/HMO insurance program and the following percentage of premium allowance schedule.

Years of Active Participation in the Welfare Fund	Allowance %
5 through 14	15%
15 Through 19	25%
20 years or more	50%

If the retiree purchases hospital and medical insurance coverage other than the HIP/HMO, the reimbursement allowance will still be based on the current premium applicable to the direct payment HIP/HMO.

A claim form specifically for this program is available by calling the Fund Office at (212) 925-0005. Along with the claim form, a participant must send a copy of the insurance premium invoice/bill, covering a three-month period, the cancelled check issued for payment of the premiums or an original paid receipt from the insurance carrier.

The health care allowance benefit for paid premiums will end on the first day of the month in which the participant reaches age 65 or whenever he/she becomes eligible to receive Medicare benefits, whichever comes first

Exclusions
The principal exclusions of this program are: all Medicare Part B premiums, premiums for Supplemental to Medicare Part A and B insurance, premiums for Medicare Part C, premiums for any other government sponsored health benefit programs, premiums under which the participant is covered as a dependent and premiums applicable to Major Medical, Catastrophic or Long Term Care insurance contracts.

Survivor Benefit-Retiree

Since July 1, 1992, the Welfare Fund has provided a benefit in the event of the death of a retired participant if he/she retired before 1990. As of January 1, 1998, the benefit was increased to $5000, regardless of the retirement date. This benefit is self-funded. If more than one beneficiary is designated, the benefits will be shared equally by the named beneficiaries.

A Designation of Beneficiary form must be on file in the Fund Office.

Your Beneficiary
Retired participants must choose, and designate by completing the Designation of Beneficiary Form, the person(s) who is (are) to receive the benefit upon his/her death. If married, the spouse must be designated as a beneficiary, unless a waiver of benefit is signed by the spouse and notarized. Other designated beneficiaries may be anyone regardless of relationship to the retiree. The Designation of Beneficiary Form is available by calling the Welfare Fund Office.

- A minor child can be designated beneficiary as long as a legal guardian has been assigned and noted on the Beneficiary Form.
- A contingent beneficiary will be eligible only in the event of the death of the designated beneficiary(ies).
- If a beneficiary has not been designated, the benefit is payable to the deceased retired participant's estate.

Please note: Federal legislation mandates that all self-funded death benefit payments are subject to income tax payable by the beneficiary(ies), for deaths occurring on or after August 1996.

Please Note: The benefits and eligibility rules applicable to retired employees and their spouses have been established by the Trustees as part of an overall Retiree Health and Welfare Benefits Program. The right to amend or modify the eligibility rules and Plan of Benefits for retired employees and their spouses is reserved by the Board of Trustees, in accordance with the Declaration of Trust. The continuance of benefits for retirees and their spouses and the eligibility rules therefore are subject to modification and revision by the Board of Trustees in accordance with their responsibilities and authority as contained in the Declaration of Trust.

In accordance with the rules and regulations and the Trust Agreement, no employee has a vested interest in the benefits provided for retired employees and their spouses. In the event of termination of the Welfare Fund and its Plan of Benefits, the Trustees reserve the right to terminate this program of benefits for retired employees and there shall not be any vested right by any retired employee after the disposition of all Plan assets and the termination of the Plan. Retired employees and their spouses shall not have any priority with respect to the disposition of Plan assets in connection with the termination of this Welfare Fund.

SUPPLEMENTAL WELFARE FUND BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS WITH MEDICARE

Once you reach age 65, you are eligible for Medicare benefits even if you are still working. You can delay your enrollment in Medicare until you retire. However, it may be to your advantage to sign up for Medicare when you first become eligible at age 65, since Medicare coverage would be available to you during periods of unemployment. You must apply for Medicare at your local Social Security office at least three months before you reach age 65 to have your coverage become effective when you reach age 65.

Medicare traditionally has consisted of two parts: Part A which provides hospital benefits, and Part B which provides medical benefits. Part A is provided at no cost to you; there is a monthly premium for Part B. Effective January 1, 1999, Medicare Part C was added, which includes a choice of managed care plans, including HMO coverage, as well as medical savings accounts combined with high-deductible medical plans and other coverage options. For Medicare Part C coverage, you pay the Part B premium amount plus in some instances an additional premium amount, depending on the plan chosen. The day care center employee should visit his/her Social Security Administration Office regarding the Medicare Insurance program. The Social Security Administration office is the best source for Medicare information.

If you and/or your covered spouse are age 65 or older and become covered by Medicare while you are an active employee, you and/or your covered spouse will have the same coverage as any other active employee and covered spouse. Call the Welfare Fund Office for more information about retaining your benefits if you continue working past age 65.

The GHI/Blue Cross or HIP/HMO basic health plans together with the Welfare Fund supplemental benefits will pay first (primary source of medical coverage) and Medicare will pay second (secondary source of medical coverage) for as long as you continue working, provided you elect employer coverage as your primary source of coverage.

After you receive benefits through the GHI/Blue Cross or HIP/HMO basic health plans together with the Welfare Fund, you may submit a claim for unpaid balances to Medicare Parts A and B for additional payment, if any. Be sure to submit your claims to this Fund first for benefits covered and provided by the Fund.

If your covered spouse or dependent child becomes covered by Medicare due to disability, that covered dependent will have the same coverage as any other dependent of an active employee. If you or your covered dependent becomes entitled to Medicare due to end stage renal disease (ESRD), this Plan will pay first for benefits provided by the Fund and Medicare will pay second for a limited period of time.

If you and/or your covered dependent are enrolled in Medicare and you want Medicare to pay first, you and/or your covered dependent are not legally entitled to Welfare Fund supplemental benefits – only Medicare coverage would then be available to pay health expenses. COBRA continuation coverage is available for covered dependents that lose Fund health coverage because the active employee elects Medicare and drops the Welfare Fund's coverage.

SUBROGATION AND RIGHT OF RECOVERY

If either you or your covered dependent is legally entitled to a recovery from a third party for damages of any kind or for hospital and/or medical expenses incurred as a result of an accident alleged to be the fault of such third party, the Plan will have the right to be reimbursed out of any such recovery (whether by way of judgment, settlement or otherwise) for the hospital and/or medical and/or benefit expenses so incurred by the Plan. Such reimbursement will be without regard to how much of the recovery is for damages and how much for hospital and/or medical and/or other expenses.

If either you or your covered dependent is involved in such a case, by accepting benefit payments under this Plan, you become automatically obligated to restore to the Plan the amount it is entitled to recover and you agree to furnish any information and assistance and to sign any appropriate form the Plan may reasonably request to enforce its right of recovery including any and all documents requested by the Plan to enable it to effect a valid lien upon such recovery in favor of the Plan or its insurer and against the third party, you or your covered dependents or respective attorneys, as the case may be.

Also, you and your dependents shall take no action to prejudice such rights of the Plan. Failure or refusal to cooperate fully may result in discontinuance or suspension of benefits.

You and your covered dependent's rights to receive benefits under this Plan will not be affected in any way by this provision provided you cooperate fully with the Plan to implement the subrogation provisions.

No-fault Insurance

If you require care as a result of an automobile accident, all claims for service must be submitted to your or the car owner's insurance carrier. In the event that your or the owner(s) car insurance carrier does not pay the total expenses resulting from the automobile accident, a claim for benefits normally provided by the Welfare Fund for the amount not covered by the car insurance carrier may be submitted to the Fund Office for review.

CLAIMS REVIEW AND APPEAL PROCEDURE

This section describes the procedures for filing claims for benefits from the Day Care Council-Local 205, District Council 1707 Welfare Fund. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

How Do I Submit a Claim?

To submit a claim for reimbursement, you must follow these steps:

- Obtain a claim form from the Fund Office.
- Complete the participant part of the form.
- Include the participant's identification number.
- Have the health care provider complete the provider's part of the form.
- Send the completed form to the Fund Office.
- Include required supporting documentation such as receipts, grades, etc.

For Disability Income Supplement Claims the following is also needed:

- Copies of the original disability claim filed by the participant and Center, and
- Copies of disability check stubs and/or copies of correspondence received from the disability insurance carrier.

Presenting a prescription at a pharmacy is not a claim for benefits.

How Do I Submit a Claim For Reimbursement That I Have Already Paid?

To submit a claim for reimbursement, follow the steps described above and attach all paid invoices. The invoices must show:

- The name of the participant and the participant's identification number.
- The name of patient.
- The name, address and telephone number of health care provider.
- Treatment diagnosis.
- Type of services rendered, with diagnosis and/or procedure codes.
- Date of services.
- Prescription for item or service.
- Itemized charges.
- Original receipt.

The participant's identification number must be on each claim.

When Should I File My Claim?

All claims for benefits must be submitted on claim forms made available by the Welfare Fund Office. Original claim form submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

Claims should be filed within 90 days of the date the charges were incurred. Benefits will be paid based on the plan's provisions on the date charges were incurred. Charges are considered "incurred" when treatment or care is given or a procedure is performed or an appliance is received.

The claim-filing deadline for all Welfare Fund self-insured benefits is one (1) year from the date of service and postmarked no later than December 31 of the filing year.

Where Do I Submit a Claim For Reimbursement?

Hospital Benefits

No claims need to be filed to receive your hospital benefits if you or a covered dependent register for inpatient or outpatient services with a hospital in Empire Blue Cross Blue Shield Inc.'s network, or a hospital participating with another Empire Blue Cross Blue Shield plan. You simply present your Empire Blue Cross Blue Shield, Inc. identification card at the facility. If you or your covered dependent register with an out-of-area or non-participating hospital, you may have to pay the

hospital's bill. In this case, for reimbursement, send a claim form with the original itemized bill including the following information:

- The patient's name and date of birth
- The Empire Blue Cross Blue Shield, Inc. identification number
- The Subscriber's name and address
- The date of each service
- The charge for each service

to the following address **within 18 months of the date you received the service:**

Empire Blue Cross Blue Shield, Inc.
P.O. Box 1407
Church Street Station
New York, NY 10008-1407

Keep a copy of your original bill for your records. See your separate booklet issued by Empire Blue Cross and Blue Shield available from the Fund Office, free of charge, for additional information.

Dental Benefits
All completed dental claims should be submitted on the GHI Dental Claim form and mailed to the following address:

GHI
Dental Claim Department
441 Ninth Avenue - 5th Floor
New York, NY 10002

Prescription Drug Benefits
If you wish to obtain prescription drugs at a non-participating pharmacy, you will have to pay the charge, then complete a Direct Drug reimbursement claim form to receive reimbursement. You may obtain a reimbursement claim form from the Fund Office. You and the pharmacist must complete and sign the claim form. Complete one claim form for each prescription and mail it to the following address:

Medco Health
P.O. Box 2187
Lee's Summit, MO 64063-2187

You will be reimbursed directly up to the maximum allowable cost of the prescription, less the co-payment. The maximum allowable cost may, in some cases, be less than the actual charge you paid for the prescription.

Orthodontic, TMJ Appliance Benefit, Optical, Professional Nursing, Ambulance/Ambulette, Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances Benefits, Supplemental Welfare Fund Benefits While Disabled, Disability Income Supplement and Survivor Benefit Claims

All claims for the above benefits must be submitted on the appropriate claim form which can be obtained from the Welfare Fund Office. Mail the completed claim and supporting documentation to the Day Care Council – Local 205, D.C. 1707 Welfare Fund at the following address:

DCC – Local 205, D.C. 1707 W.F.
75 Varick Street
New York, NY 10013-1917

Who Decides If My Claim Is Covered?

The Fund administrator makes the initial determination about whether your claim is covered under the Fund. However, the Fund Administrator's determination may be reviewed by the Trustees of the Fund. The Trustees have exclusive authority and discretion to determine whether an individual is eligible for benefits, to determine the amount, if any, of an individual's benefit, and to interpret and construe the terms and provisions of the Fund's documents and summary plan description. The Trustees' interpretations and determinations are final and binding upon any individual claiming benefits from the Fund, will be given deference in all courts of law to the greatest extent allowed by law, and may not be overturned or set aside unless found to be clearly arbitrary and capricious or made in bad faith. All determinations will be based upon clearly defined and ascertainable criteria contained in the Fund's documents or summary plan description and, if applicable, any rules and procedures adopted by the Fund. Claim determinations will be made in a manner that consistently applies the terms of the Plan with respect to similarly situated claimants.

When Will I Be Notified If My Claim Is Denied?

If your claim is denied (whether denied in whole or part), you will be advised within a reasonable period of time, but not later than 30 days after receipt of the claim by the Fund. If the Fund administrator determines that an extension of time is required, you will receive written notice of the extension prior to the termination of the initial 30-day period, the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If the extension is due to reasons beyond the control of the Fund, the extension will be no longer than 15 days. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Special Rule for Pre-Certification Claims. If your claim for benefits requires pre-certification, you will be notified more quickly. You will be notified (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Fund. If the Fund administrator determines that an extension of time is required, you will receive written notice of the extension prior to the termination of the initial 15-day period, the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If the extension is due to reasons beyond the control of the Fund, the extension will be no longer than 15 days. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Special Rule for Urgent Care Claims. Special rules apply, if your claim for benefits requires pre-certification of treatment involving urgent care. A claim involving urgent care is a claim for benefits to which the application of the usual time periods for making pre-certification determinations could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a claim involving urgent care will be determined by the Fund administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a physician with knowledge of your medical condition determines is a claim involving urgent care, will be treated as such.

If your claim involves urgent care, the Fund administrator will notify you of the Fund's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Fund, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable by the Fund. In the case of such a failure, the Fund administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Fund, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Fund administrator will notify you of the Fund's benefit determination as soon as possible, but in no case later than 48 hours after the Fund's receipt of the specified information or, if earlier, the end of the period afforded you to provide the requested additional information.

Concurrent care decisions. If the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Fund of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Fund administrator will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is

reduced or terminated. Any request to extend the course of treatment for urgent care services beyond the period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Fund administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Fund, provided that any such claim is made to the Fund at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If treatment is not for urgent care, the claim will be decided within the same timeframe as pre-service claims.

Disability Claims (Disability Income Supplement Claims). A Disability Claim is any claim that requires a finding of total disability as a condition of eligibility. See the "Disability Income Supplement For the Participant" section of this booklet for more information.

For Disability Claims, 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 the control of the Plan, 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 administrator 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 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). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within 30 days.

For Disability Claims, the plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

Survivor Benefit Claims. A Survivor Benefit Claim is a claim made by your beneficiary on the occasion of your death. The following procedure applies to these claims.

- Your beneficiary, as applicable, must obtain a claim form from the Fund Office.
- Complete the original claim form.
- Attach proof of death to the claim form.
- Return the completed claim form and all necessary documentation to the Fund Office.

For Survivor Benefit Claims, the Fund will make a decision on the claim and notify your beneficiary within 90 days. If the Fund requires an extension of time due to matters beyond its control, it will notify the beneficiary in writing of the reason for the delay, and the date as of which the Fund expects to render a decision. This notification will occur before the expiration of the 90-day period. In no event, however, will this extension exceed 90 days of the time the Fund notifies your beneficiary of the delay. If an extension is needed because additional information is needed from the beneficiary, the extension notice will specify the information needed. Until this additional information is supplied, the normal period for making a decision on the claim will be suspended.

How Will I Be Notified That My Claim Has Been Denied?

If your claim is denied (whether denied in whole or part), you will receive written notice of such denial. The notice will set forth:

- The specific reason or reasons for the adverse determination.
- The specific Plan provisions on which the determination is based.

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Fund's review procedures and the time limits applicable to such procedures.
- If applicable, a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy thereof will be provided free of charge upon request.
- If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limitation, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request.
- In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.
- Further, in the case of an adverse benefit determination concerning a claim involving urgent care, a notice may be provided orally, provided that a written notification is furnished not later than 3 days later.

Can I Request a Review of a Claim That Is Denied?

You or your duly authorized representative may appeal the denial (whether denied in whole or part) of any claim. Your appeal will receive a full and fair review. You will have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals will be reviewed in accordance with the terms of the Plan and, if applicable, rules and procedures adopted by the Trustees. Appeal determinations will be made in a manner that consistently applies the terms of the Plan with respect to similarly situated claimants.

You must file your appeal in writing no later than 180 days following receipt of a notification of an adverse benefit determination in the case of a claim involving Hospital, Dental, Prescription Drug, Orthodontic, TMJ Appliance Benefit, Optical, Professional Nursing, Ambulance/Ambulette, Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances Benefits, Disability Income Supplement benefits. Your beneficiary must file an appeal within 60 days in the case of a claim involving Survivor benefits.

Hospital Appeals

All appeals should be made in writing to
Empire Blue Cross Blue Shield at:
Appeals and Grievances
PO Box 1407
Church Street Station
New York, New York 10008

Dental Appeals

All appeals should be made in writing to GHI at:
GHI
Appeals and Grievances
PO Box 4007
New York, New York 10023

Prescription Drug

All appeal should be made in writing to
Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, Texas 75063

Orthodontic, TMJ Appliance Benefit, Optical, Professional Nursing, Ambulance/Ambulette, Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances Benefits, Supplemental Welfare Fund Benefits While Disabled, Disability Income Supplement and Survivor Benefits

All appeals should be made in writing to the Board of Trustees at:

DCC – Local 205, DC 1707 WF
75 Varick Street
New York, NY 10013-1917

Your appeal will be considered by the Trustees by a Fund official who is neither the person who made the initial determination (nor a subordinate of such person). Your appeal will be reviewed without deference to the initial adverse benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or appropriate Fund official will consult with a health care professional who has training and experience in the field of medicine involved in the medical judgment. The medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination will be identified without regard to whether the advice was relied upon in making the benefit determination. The health care professional engaged for purposes of a consultation with the Trustees or appropriate Fund official will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

You may request an expedited review of the denial of a claim involving urgent care. You may make such a request orally or in writing. All necessary information, including the Fund's benefit determination on review, may be transmitted between you and the Fund by telephone, facsimile, or other similarly expeditious method.

How Will I Be Notified of the Funds Review of My Appeal?

Hospital and Dental Benefits
Since appeals regarding hospital and dental benefits are made to Empire Blue Cross Blue Shield or GHI, respectively, you will be notified by Empire Blue Cross Blue Shield or GHI of the determination of your claim under review.

Prescription Drug, Orthodontic, TMJ Appliance Benefit, Optical, Professional Nursing, Ambulance/Ambulette, Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances Benefits, Supplemental Welfare Fund Benefits While Disabled, Disability Income Supplement and Survivor Benefits

The Trustees will make a determination regarding appeals for the denial of benefits (except claims requiring pre-certification or claims for urgent care) no later than the date of the Trustees' meeting immediately following the Fund's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made by no later than the date of the second Trustees meeting following the Fund's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Trustees following the Fund's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund will provide you with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trustees will notify you of the determination soon as possible, but not later than 5 days after the benefit determination is made.

Pre-certification claims. For claims requiring pre-certification, the appropriate Fund official will notify you of the Fund's determination on review not later than 30 days after receipt by the Fund of your request for review.

Urgent care claims. For claims involving urgent care, the appropriate Fund official will notify you of the Fund's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Disability Income Supplement. Upon receipt of an appeal of a denial for benefits under the Plan, the Fund Official will respond to you within 45 days after receipt of the claim. If the Fund Official determines that an extension is necessary due to matters beyond the control of the Plan, you will be notified within the initial 45-day period that the Fund Official needs up to an additional 45 days to review your claim.

Survivor Benefit Claims. Upon receipt of an appeal of a denial for benefits under the Plan, the Fund Official will respond to you within 45 days after receipt of the claim. If the Fund Official determines that an extension is necessary due to matters beyond the control of the Plan, you will be notified within the initial 45-day period that the Fund Official needs up to an additional 60 days to review your claim.

Manner and content of notification of benefit determination on review.

If your appeal is denied, you will receive written notice of such denial. The notice will set forth:

- The specific reason or reasons for the adverse determination.
- The specific Plan provisions on which the determination is based.
- A description of any additional material or information necessary for you to perfect the appeal and an explanation of why such material or information is necessary.
- A statement that you may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy thereof will be provided free of charge upon request.
- If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limitation, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances, will be provided free of charge upon request.
- The following statement: "You and your Fund may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

How Are the Time Periods For the Benefit Determination Or Appeal Determined?

The period of time within which a benefit determination or appeal is required to be made will begin at the time a claim or appeal is filed with the Fund, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to make a determination on a claim, the period for the determination will be extended from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

CONTINUATION OF COVERAGE

Continuation of Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), allows you and your covered dependents to continue health care coverage at your own expense under certain circumstances when health care coverage would otherwise end. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered dependents may continue the same coverage that you had before the COBRA-qualifying event, including:

a) CityWide Central Insurance Program (CCIP) offers you the opportunity to continue the same group GHI-Medical or HIP/HMO coverage that you had while employed at a day care center. For further information on COBRA regarding benefits provided by your CityWide Central Insurance Program (CCIP), call (212) 788-8142.

b) The Welfare Fund also offers you the opportunity to continue the same Fund provided supplemental benefits that you had while employed at a unionized and contributing Day Care Center:
   - Extended Coverage Rider for hospital insurance for participants enrolled in the GHI Medical option,
   - Dental, Orthodontic, TMJ Appliance Benefits,
   - Prescription Drug Benefits,
   - Optical Benefit,
   - Ambulance/Ambulette Benefit,
   - Professional Nursing Benefit, and
   - Prosthetic, orthopedic and Prescribed Durable Medical Equipment/Appliance Benefit

c) The Welfare Fund additionally offers you the opportunity to continue the same Fund administered benefits that you had while employed at a unionized and contributing Day Care Center for Hospital Insurance (Basic) for participants enrolled in the GHI Medical Option.

COBRA does not apply to the following benefits:
- Survivor Benefit,
- Supplemental Disability Income benefit,
- Tuition Assistance Benefit,
- Group Legal Fund Services Benefit, and
- Retiree Benefits Program.

COBRA Eligibility (COBRA-Qualifying Events)

For You

COBRA coverage is available to you if coverage would otherwise end if:
- You do not work the required number of hours to maintain participation in the Fund's supplemental health benefits program.
- Your employment ends for any reason other than gross misconduct.

For Your Dependents

COBRA coverage is available to your covered dependents if coverage would otherwise end if:

- You do not work the required number of hours to maintain participation in the Fund's health insurance benefits program.
- You (the active participant) end employment for any reason other than gross misconduct.
- You (the active participant) die, get divorced, become legally separated, or become entitled to Medicare (and voluntarily drop Fund coverage due to the Medicare entitlement
- Your dependent child ceases to be eligible for Fund coverage, for example, he or she marries or reaches the maximum age limit for coverage.

Taking leave under the Family and Medical Leave Act (FMLA) does not constitute a qualifying event. However, failure to return to work with your employer at the end of the FMLA leave will constitute a qualifying event to the extent that coverage is lost, prior to the end of what would be your COBRA maximum coverage period, under the Plan.

How COBRA Coverage Works

The following is the name, address and telephone number of the person who is responsible for administering COBRA Continuation Coverage for the Fund:

Ms. Iris N. Jusino
Fund Administrator
DCC – Local 205 WF
75 Varick Street
New York, NY 10013-1917
(212) 925-0005

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

Providing Notice of Qualifying Events

Your employer will usually notify the Fund Office of your death, termination of employment, reduction in hours, retirement, or entitlement to Medicare. However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification. It is also important that you notify the Fund Office of a COBRA-qualifying event in your life or in the life of your spouse and/or dependent child(ren) so that the Fund Administrator can provide you and/or them with a certificate of creditable coverage.

The time period in which your employer must notify the Fund Office of your death, termination of employment, reduction in hours, retirement, or Medicare entitlement will begin to run from the date of your loss of coverage and not the date of the qualifying event.

You and/or a family member are responsible for providing the Fund Administrator with timely notice of the following qualifying events:

(1) The divorce or legal separation of the covered employee from his or her spouse.

(2) A child ceasing to be covered under the plan as a dependent child of the covered employee.

(3) The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include the covered employee's death, entitlement to Medicare, divorce or legal separation or a child losing dependent status.

In addition to these qualifying events, there are two other situations where you and/or a family member must provide the Fund Administrator with notice within the timeframe noted in this section:

(4) When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If the determination is made that an individual is disabled at any time during the first 60 days of COBRA coverage, the qualified beneficiary (and each other qualified beneficiary entitled to the 18-month period of COBRA due to the same initial event) may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.

(5) When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

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

Manner in Which You Must Provide Notice

Notice of any of the five situations listed above must be provided in writing. You may use the Fund's "COBRA Notice Form for Covered Employees and Qualified Beneficiaries" to provide notice to the Fund. You may obtain a copy of this form by Calling the Fund Office at 212 925-0005. Alternatively you may send a letter to the

Fund containing the following information: your name, which of the five events listed above you are providing notice, the date of the event, the date in which you and/or your beneficiary will loss coverage and any supporting documentation.

Notice should be sent to:

Ms. Iris N. Jusino
Fund Administrator
DCC – Local 205 WF
75 Varick Street
New York, NY 10013-1917
(212) 925-0005

When the Notice Should Be Sent

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

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days after the later of** (1) the date of the disability determination by the Social Security Administration (2) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund Manager. Notwithstanding the previous sentence, notice must be sent no later than the end of the first 18 months of 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 later of** the date of the determination by the Social Security Administration that you are no longer disabled. [The date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsibility to provide the notice and the procedures for providing this notice to the Fund Administrator.]

If the notice has not been received by the Fund by the end of the applicable period described above, you and/or your spouse and/or dependent will not be entitled to choose/extend COBRA Continuation Coverage.

Who May Provide a Notice

Notice may be provided by the covered employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee 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 you, the employee, your spouse and your child are all covered by the Plan, and you and your spouse decide to legally separate, a single notice sent by your spouse would satisfy this requirement.

Once you have provided notice, the Fund Office will send you information about COBRA coverage.

How To Elect COBRA Continuation Coverage

When your employment terminates or you work few enough hours so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or legally separated, became entitled to Medicare (and voluntarily dropped Fund coverage), or that a dependent child lost dependent status under the Plan, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms you need to elect COBRA Continuation Coverage.

Under the law, you and/or your covered dependents will then have only 60 days from the date you or they receive that notice to apply for COBRA Continuation Coverage.

If you and/or any of your covered dependents do not choose COBRA continuation coverage within this 60-day period, you and/or they will not have any group health coverage from this plan after coverage initially ended.

If you notified the Fund Office of a qualifying event and you are not entitled to COBRA coverage, the Fund Office will send you a written notice stating the reason you are not eligible for COBRA. The Fund Office will provide this notice within 30 days after its receipt of your notice of a qualifying event.

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage. One or more covered dependents may elect COBRA even if the employee does not elect it. One member of the family may elect COBRA for other members of the family. COBRA Continuation Coverage may be elected for some members of the family and not others. In order to elect COBRA Continuation Coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event. A parent or legal guardian may elect or reject COBRA Continuation Coverage on behalf of covered dependent children.

Additional COBRA Election Period and Tax Credit in Cases of Eligibility for Benefits Under the Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents do not elect COBRA during your election period described above, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you are certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ends under the Plan.

Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp. The Fund Manager may also be able to assist you with your questions.

The COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same Welfare Fund Supplemental Benefits Coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the sections entitled "Cost of COBRA Continuation Coverage" and "Paying for COBRA Coverage", below, for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the Welfare Fund Supplemental Benefits Coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

Cost of COBRA Coverage

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, on an after-tax basis, except in cases of extended COBRA coverage due to Social Security disability. See the section entitled "COBRA Coverage in Cases of Social Security Disability" for more information.

Paying For COBRA Coverage

The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended

COBRA coverage due to Social Security disability. See the section entitled "Cost of COBRA Coverage in Cases of Social Security Disability" for further information.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. **If payment of the amount due is not made by the end of this grace period, your COBRA coverage will terminate.**

If payment is received by the deadline but is short no more than the lesser of (a) $50 or (b) 10% of the required monthly amount, the Fund Office will notify you of the deficiency, and you will be given a 30-day extension of time to pay it.

COBRA AT-A-GLANCE

COBRA Coverage May Continue For:	**If the Following Event Occurs and Coverage is Lost:**	**Maximum Length of COBRA Coverage:**
You and Your Eligible Dependents	• Your employment ends (for example, you resign) for any reason except gross misconduct. • You work too few hours to remain eligible to participate in the Fund's health insurance program.	18 months (29 months if you or your eligible dependents is Social Security - disabled*).
Your Eligible Dependents Only	• You die. • You are divorced or legally separated. • You become entitled to Medicare (and voluntarily drop fund coverage). • Your child(ren) no longer qualifies as an eligible dependent under the Plan.	36 months

*See "COBRA Coverage In Cases of Social Security Disability" for more details.

Duration of Cobra Coverage

Your COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA-qualifying event.

The COBRA Continuation Coverage period begins on the date you and/or your covered dependents lose coverage (rather than on the date of the qualifying event).

18 Months
COBRA health coverage can continue for up to 18 months if you would otherwise lose Fund health coverage because:

- You work too few hours to continue participation.
- You change from active to inactive work status due to your:
  - ➢ Resignation.
  - ➢ Discharge (except for discharge for gross misconduct).
  - ➢ Disability.
  - ➢ Strike.
  - ➢ Layoff.
  - ➢ Retirement.
  - ➢ Leave of absence (other than leave under the Family and Medical Leave Act).

29 Months
COBRA health coverage can continue for up to a total of 29 months if you or an eligible dependent becomes permanently disabled (as determined by the Social Security Administration) within the first 60 days of COBRA coverage, and you or your eligible dependent notifies the Fund Office of the determination no later than 60 days after it was received and before the end of the initial 18-month COBRA period.

36 Months
COBRA health coverage for your eligible dependents can continue for up to a total of 36 months from the date of loss of Plan coverage due to the occurrence of any one of the following COBRA-qualifying events:

- Your death.
- Your divorce or legal separation.
- Your entitlement to Medicare (if you voluntarily drop Fund coverage).
- Your dependent is no longer eligible for Fund coverage.

Cobra Coverage in Cases of Social Security Disability

If you, your spouse, or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the 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 (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage.
- The disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Plan is notified by you or your eligible dependent that the determination was received:
  - —No later than 60 days after it was received; and
  - —Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earlier** of:

- The last day of the month, 30 days after Social Security has determined that you and/or your eligible dependent(s) are no longer disabled.
- The end of 29 months from the date loss of coverage due to the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

Cost of COBRA Coverage in Cases of Social Security Disability

If the 18-month period of COBRA Continuation Coverage is extended because of Social Security disability, the Plan will charge members and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

Acquiring a New Dependent(s) While Covered by COBRA

If you, your spouse, or your dependent child elects COBRA and acquires a new dependent through marriage, birth, adoption or placement for adoption while enrolled in COBRA Continuation Coverage, that person may add the dependent to COBRA coverage for the balance of the COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage.

To enroll your new dependent for COBRA coverage, notify the Fund Office with in 31 days after acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you, your spouse or your dependent child before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for the newly added dependent. Check with the Fund for more details on how long COBRA coverage can last.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent child loses coverage under another group health plan, you may enroll the spouse or dependent child 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 the 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 had other health insurance coverage.

You must enroll the spouse or dependent within [31 days] after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Multiple Qualifying Events While Covered by COBRA

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, divorce or legally separate, become entitled to Medicare, 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 up to 36 months from the date of loss of coverage due to the occurrence of your termination of employment or reduction of hours.

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your eligible dependents for COBRA coverage. Three months after your COBRA coverage begins, you divorce and your former spouse is no longer eligible for Plan coverage. Your former spouse can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after your loss of coverage due to the termination of employment or reduction of 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 active member) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or if you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability). As a result, if you experience a reduction of hours then have a 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 date of loss of coverage due to the occurrence of the initial qualifying event.

Termination of Employment/ Reduction of Hours Following Medicare Entitlement

If you become entitled to (enrolled in) Medicare and you later have a termination of employment or reduction of hours, then your spouse and/or your dependent child would be entitled to COBRA Continuation Coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of hours or 36 months from the date you become entitled to Medicare, whichever is longer.

When COBRA Coverage Will Be Cut Short

Once COBRA coverage has been elected, it will be cut short on the occurrence of any of the following events:

- The first day of the time period for which you do not pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a pre-existing condition that the Covered Person may have.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to (enrolled in) Medicare (usually age 65).
- If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed no longer disabled by SSA.
- If you take actions that would result in termination of active employee coverage (for example, if you submit false claims to [insurer].)
- When the Employer that employed you prior to the qualifying event has stopped contributing to the Plan

If COBRA coverage is cut short as described above, the Fund Administrator will send you a written notice as soon as practicable following his or her determination that COBRA coverage will terminate. The notice will set out why COBRA coverage will terminate early, the date of termination, and your rights, if any, to alternative individual or group coverage.

When Cobra Coverage Ends

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) ends.

Conversion of Coverage for Participant's Enrolled in the Hospital Benefits Under Empire Blue Cross Blue Shield

You may convert your group coverage to a direct payment contract that contains benefits comparable to your group coverage; however, not all of your current benefits may be available on a direct payment basis.

You may convert under any of the following circumstances:

- you, your spouse, or your dependent child no longer qualifies as a family member under the contract because
  a) the child no longer qualifies as a covered dependent
  b) a covered incapacitated child no longer qualifies as incapacitated
  c) a spouse either divorces or annuls the marriage to the employee
  d) the employee dies.
- you no longer qualify as a group member
- your company no longer meets our underwriting standards
- your company terminates the contract and does not offer replacement coverage to group members.

You must advise your company before either you or a covered dependent loses eligibility so that we can continue your coverage under a conversion contract. If an interruption between coverage occurs, you may have to satisfy a new waiting period.

To convert to a new direct payment contract, you must apply within 90 days of the termination's effective date. To obtain either an application or additional information, call 1-800-261-5962.

After applying for direct payment coverage, you must pay the premium for the new contract when due.

By following these directions, both you and your dependents will avoid both interrupted coverage and new waiting periods.

- You may **not** convert this contract if coverage ends because:
- you either fraudulently filed the Notice of Election, **or**
- you were never a group member, **or**
- you are Medicare eligible and live outside New York State, **or**
- the group replaced this contract with similar continuous coverage.

Other reasons, including but not limited to filing false or improper claims, may also restrict contract conversion.

Confirmation of Coverage To Health Care Providers

Under certain circumstances, federal rules require the Fund to inform your health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule is applicable under the following two circumstances.

1. If a health care provider requests confirmation of coverage during the COBRA election period, and you, your spouse or your dependent child(ren) have not yet elected COBRA continuation coverage, then the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during the election period.

The Fund cancels your and your dependents' coverage as of the date coverage ends under the Plan. However, the Fund retroactively reinstates your coverage once COBRA continuation coverage is elected. If you have not yet elected COBRA, the Fund Office will inform the health care provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the date coverage was lost if you elect COBRA continuation coverage.

2. If, after you have elected COBRA continuation coverage, a health care provider requests confirmation of coverage for a period for which the Fund Office has not yet received payment; then the Fund Office will give a complete response to the health care provider about you and your dependents' COBRA continuation rights during that period.

The Fund cancels your and your dependents' coverage as of the first day of a period of coverage if it has not received your or your dependents' COBRA payment. However, the Fund retroactively reinstates your coverage once the COBRA payment is made. If you and/or your dependents have not paid the applicable COBRA payment, the Fund Office will inform the health care provider that you do not currently have coverage, but that you and your dependents would have coverage retroactively to the first day of the period of coverage if timely payment is made.

Continuation Under New York State Law

If you are not entitled to continuation of coverage under COBRA, you may be entitled to continuation of coverage under the provisions of the New York State Insurance Law for your hospital and major medical benefits. For more information on the basic hospital and medical benefits provided by the CityWide Central Insurance Program (CCIP), contact (212) 788-8142. If you and/or your dependents are enrolled in the basic and extended group hospital insurance provided by Empire Blue Cross and Blue Shield contact the Welfare Fund Office for more information. This coverage may be continued for up to eighteen(18) months on a direct group payment basis.

HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When your coverage ends you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time you and/or your dependent(s) were covered under the Plan (including, if applicable, COBRA coverage), as well as certain additional information required by law.

This certificate may be necessary if you and/or your dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy within 63 days after your coverage under this Plan ends (including, if applicable, COBRA coverage). The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents under the new group health plan or health insurance policy.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for you and/or your covered dependent(s) has ended.

Under the Plan, the Fund Office sends this certificate for all of the supplemental benefits. You may request to receive a certificate for this benefit coverage from the Fund Office, and the Fund Office will provide one to you, if you make your request within two years after the later of the date your coverage under this Plan ended or the date your COBRA coverage ended.

The Fund Office will send you (or any of your covered dependents) a certificate by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered dependents) elect COBRA coverage, another certificate will be sent to you (or them if COBRA coverage is provided only to them) by first class mail shortly after the COBRA coverage ends for any reason.

Please address all requests for certificates of creditable coverage to:

Fund Administrator
DCC-Local 205 WF
75 Varick Street
New York, NY 10013-1917

STATEMENT OF PRIVACY PRACTICES

The Day Care Council – Local 205, D.C. 1707 Welfare Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI);
- Your privacy rights with respect to your PHI;
- The Fund's duties with respect to your PHI;
- Your right to file a complaint with the Fund and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Fund's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Fund, regardless of form (oral, written or electronic).

Section 1- Statement of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Fund is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Fund's compliance with the privacy regulations.

The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Fund also will disclose PHI to the Board of Trustees for purposes related to treatment, payment and health care operations. The Board of Trustees has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Fund may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Section 2- Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Fund to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Fund is not required to agree to your request.

The Fund will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following office:

Iris N. Jusino
DCC - Local 205 WF
75 Varick Street
New York, New York 10013
(212) 925-0005

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Fund, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decision about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to Iris N. Jusino, Privacy Officer, DCC-Local 205, DC 1707 WF, 75 Varick Street 15th Floor, New York NY 10013, (212) 925-0005.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the Fund to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or part, the Fund must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI is a designated record set should be made to the following officer:

Iris N. Jusino
DCC - Local 205 WF
75 Varick Street
New York, New York 10013
(212) 925-0005

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.
If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost based fee for each subsequent accounting.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3- The Funds Duties

The Fund is required by law to maintain the privacy of PHI and to provide individual's (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to the date. If a privacy practice is changed, a revised version of this notice will be provided [to all past and present participants and beneficiaries] for whom the Fund still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses of disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual.
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Fund's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Fund may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4- Your Right To File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Fund in care of: Iris N. Jusino, Privacy Officer, DCC-Local 205 WF, 75 Varick Street 15th Floor, New York NY 10013, (212) 925-0005.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

The Fund will not retaliate against you for filing a complaint.

Section 5- Whom to Contact at the Plan For More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact: Iris N. Jusino, Privacy Officer, DCC-Local 205 WF, 75 Varick Street 15th Floor, New York NY 10013, (212) 925-0005.

Conclusion

PHI use and disclosure by the Fund is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Welfare Fund and Group Legal Fund of the Day Care Council- Local 205, District Council 1707, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copies 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 Benefits Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator's 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 dependent children if there is 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.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. 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 Welfare Fund benefits 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 administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in 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 frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area 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 NW, 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.

OTHER IMPORTANT PLAN INFORMATION

The following information will help you properly identify your Plan if you have any questions about your benefits. It also provides other important information about your benefits.

OFFICIAL NAME:	**Day Care Council-Local 205, D.C. 1707 Welfare Fund**	**Day Care Council Local 205, D.C. 1707 Group Legal Fund**
TYPE OF PLAN:	**Health and Welfare**	**Group Legal Service**
EMPLOYER IDENTIFICATION NUMBER (EIN):	13-2672380	13-6772380
PLAN NUMBER:	501	502

PLAN ADMINISTRATION:

The Welfare Fund and the Group Legal Fund of the Day Care Council Local 205, District Council 1707 are administered by a joint Board of Trustees composed of Union and Employer Trustees. The address of the Board is 75 Varick Street, New York, NY 10013

Union Trustees

Mr. Raglan George
Executive Director
D.C. 1707, CSAEU
75 Varick Street, 14th Floor
New York, New York 10013

Mr. Glenn Huff
President, Local 205
D.C. 1707, CSAEU
75 Varick Street, 14th Floor
New York, New York 10013

Ms. Zela Scott
Vice President, Local 205
D.C. 1707, CSAEU
75 Varick Street, 14th Floor
New York, New York 10013

Union Alternate Trustee

Ms. Luz I. Santiago
D.C. 1707, CSAEU
75 Varick Street, 14th Floor
New York, New York 10013

Employer Trustees

Ms. Andrea Anthony
Executive Director
Day Care Council of New York, Inc.
12 West 21st Street, 3rd Floor
New York, New York 10010

Mr. Wayne Mucci
Day Care Council of New York, Inc.
12 West 21st Street, 3rd Floor
New York, NY 10010

Mr. Lorenzo Newby
Chairman
Day Care Council of New York, Inc.
12 West 21st Street, 3rd Floor
New York, NY 10010

Alternate Employer Trustee

Ms. Betty Jones
Day Care Council of New York, Inc.
12 West 21st Street, 3rd Floor
New York, NY 10010

Service of Legal Process:

For disputes arising under the Plan, service of legal process may be made on the [Fund Administrator or on the] Board of Trustees at the address below:

Meyer, Suozzi, English & Klein, P.C.
425 Broadhollow Road, Suite 405
Melville, NY 11747

Service of legal process may also be made on any individual trustee.

For disputes arising under those portions of the Plan insured by Empire Blue Cross & Blue Shield and GHI, service of legal process may be made upon Empire Blue Cross & Blue Shield or GHI at one of their local offices, or upon the official of the Insurance Department in the state in which you reside.

Type of Funding:

Contributions are made to the Fund by contributing Employers according to the terms of the collective bargaining agreement(s) between the Employers and the union.

Upon written request, you may receive a list of contributing employers and employee organizations sponsoring the Plan or information as to whether a particular employer is contributing to the Plan.

Collective Bargaining Agreements

Although you should obtain copies of the collective bargaining agreements from the Union, copies of any such agreements may also be obtained by plan participants upon written request to the Plan Administrator, and are available at the Fund Office for examination by Plan participants.

Plan Year:

July 1 through June 30.

Types of Benefits and Administration

Hospital Benefits are insured by Empire Health Choice, 11 W 42nd Street, 16th Floor New York, NY 10036 and administered by the Fund. Prescription Drug Benefits are self-insured and administered by Medco Health Solutions/SYSTEMED, 100 Parsons Pond Drive, Franklin Lakes, NJ 07417 , which also administers a network of participating pharmacies and a mail order drug service. Dental Benefits are insured by Group Health Incorporated (GHI) 441 Ninth Avenue, New York, NY 10001, which also administers a network of dental providers. Optical benefits are self-insured and claims for reimbursement are administered by the Fund. The following optical providers offer discounted supplies and services to participants Comprehensive Professional Systems, Inc., 11 Hanover Square, New York, NY 10005; Vision Screening, 1919 Middle Country Road, Suite 304, Centereach, NY 11720; and General Vision Screening, 520 Eighth Avenue, 9th Floor New York, NY 10036. The Fund self-insures and administers the following benefits: Orthodontic Benefits, TMJ Appliance Benefit, Professional Nursing; Ambulance/ Ambulette; Prosthetic, Orthopedic and Prescribed Durable Medical Equipment/Appliances; Survivor Benefits, and Supplemental Disability Income benefits.

Legal Service Benefits are self-funded and provided by the law firm of Gorlick, Kravitz, and Listhaus, P.C., 17 State Street, New York, NY 10004. Tuition Assistance Benefits are self-funded and administered by the Fund.

Insurance Contract Governs

Hospital and Dental Benefits are subject to the complete terms, conditions, limitations, and exclusions of the contracts issued by Empire Blue Cross & Blue Shield and Group Health Incorporated (GHI) to the Welfare Fund. If a difference exists between the information in this booklet and the actual contracts, the contracts govern. Please consult the group contracts for additional information.

Right To Amend or Terminate the Plan

The Trustees of the Welfare Fund and Group Legal Fund of the Day Care Council- Local 205, District Council 1707 reserves the right, subject to any pertinent collective bargaining agreements, to amend, modify, suspend or terminate this Plan, or any part of it, including Retiree Benefits, at any time. Amendments are made in writing and become effective on the date of adoption, or on any other such date as may be specified in the document amending the Plan. The Trustees may also add new coverage(s).

Plan benefits for active, retired, disabled and other participants are not guaranteed. The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under this plan and (2) the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

If the Plan terminates, the Trustees will apply the assets of the Fund to provide benefits or otherwise to carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been disbursed.

The type and amount of Fund benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

Discretionary Authority of the Trustees and 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, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan, and to decide any fact related to eligibility for and entitlement to Plan benefits. 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 Practice of Medicine or Dentistry

The Plan, the Trustees, or any of their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Privacy, Confidentiality, Release of Records or Information

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

1. Information will be disclosed to those who require that information to administer the Plan or to process claims.
2. Information relating to duplicate coverage(s) will be disclosed to the plan or provider that provides duplicate coverage.
3. Information needed to determine if health care services or supplies are medically necessary or if the charges for them are Usual, Reasonable and Customary will be disclosed to the individual or entity consulted to assist the Plan Administrator or its designee to make those determinations.
4. Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related, and that occurred while the Plan Participant was covered under the Plan.

ACS/ACD: Administration for Children's Services/Agency for Child Development.

Active Course of Orthodontia Treatment (Dental): The period beginning when the first orthodontic appliance is installed and ending 30 consecutive months from the first date of treatment up to a maximum of 20 visits.

Allowable Expense: A health care service or expense, including deductibles, co-insurance or co-payments, that is covered in full or in part by any of the plans covering a Plan Participant (see also the COB section of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Ambulance/Ambulette: A vehicle that is licensed or certified for emergency patient (ground only) transportation by the jurisdiction in which it operates.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Usual and Customary Charge, after calculation of all Deductibles, Co-insurance and Co-payments, and after determination of the Plan's exclusions, limitations and maximums.

Board of Trustees: The individuals who, by law, are responsible for operating the Fund, setting Fund policies and determining benefit structure. The Board is comprised of an equal number of Union and Employer Trustees.

Calendar Year: The 12-month period beginning January 1 and ending December 31.

Child(ren): See the definition of Dependent Child(ren).

CityWide Central Insurance Program (CCIP): under the Mayor's Office of Operations, CityWide Central Insurance Program (CCIP) offers and administers the hospital and medical insurance programs for Day Care Workers. The Day Care Council- Local 205, DC 1707 Welfare Fund does not administer nor provide the medical plan benefit. For further information or answers to questions you may have about the hospital/medical insurance programs contact: CityWide Central Insurance Program at (212) 274-5769.

Coinsurance: That portion of Eligible Expenses for which the covered person has financial responsibility. In most instances, the Covered Individual is responsible for paying a fixed amount of covered expenses. In some instances, the Covered Individual may be responsible for paying a higher amount of those expenses, and in other instances, no Coinsurance applies.

Collective Bargaining Agreement: the legal agreement between the Union, CSAEU- D.C. 1707, Local 205 and the Day Care Council of New York, Inc. or Day Care Center.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits section.

Co-payment, Co-pay: The fixed dollar amount you are responsible for paying when you incur an Eligible Expense for certain services, such as prescription drugs.

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Covered Individual: An employee of a contributing Day Care Center or retiree (as that term is defined in this Plan), and that person's eligible Spouse or Dependent Child who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

CSAEU: Community and Social Agency Employees Union.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse as those terms are defined in this document. See also Eligible Dependent.

Dependent Child(ren):

A. For the purposes of this Plan, a Dependent Child is any of your "never been married"(unmarried) children for whom you provide primary support and maintenance including:
   - Your natural, adopted or placed for adoption child until the end of the calendar year in which they reach age 23,
   - Your dependent step-children until the end of the calendar year in which they reach age 23,
   - Your children or step-children over age 23 who are unable to do any work to support themselves because of mental illness, developmental disability or mental retardation as defined by New York Mental Hygiene Law, or physical handicap. The incapacity must have started before the child reached age 23, and may have to be certified by a physician.

You must submit proof of dependency status for all persons when you enroll them for Fund coverage. These proofs include copies of marriage certificates, birth certificates, and court orders of adoption.

B. Coverage of a Dependent Child ends the last day of the month in which :
   - You do not work the required number of hours to maintain participation in the Fund's supplemental welfare benefits program; or
   - You (the active participant) end employment for any reason; or
   - Your (the active participant's) own coverage ends; or
   - You (the active participant) die, get divorced, become legally separated, or become entitled to Medicare (and voluntarily drop Fund coverage;) or
   - Your dependent child ceases to be eligible for Fund coverage, for example, he or she marries or reaches the maximum age limit for coverage.

Disabled: See the definitions of Totally Disabled.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home.

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by a contributing Day Care Center who is eligible to enroll for coverage under the Plan.

Exclusions: Specific conditions, circumstances, and limitations for which the Plan does not provide Plan benefits.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; **and** written by experts in the field;

that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; **and** it has not been granted at the time the service or supply is prescribed or provided; **or a** current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will **not** be considered Experimental and/or Investigational if it is:
   - approved by the FDA as an "investigational new drug for treatment use"; or
   - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
   - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopoeia Dispensing Information"; **and** "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; **or** specialty organizations recognized by the AMA; **or** the National Institutes of Health (NIH); **or** the Center for Disease Control (CDC); **or** the Office of Technology Assessment; **or** the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare Coverage Issues Manual."

Fund Administrator: The person, firm and/or company designated by the Board of Trustees to handle the daily administrative duties of the Plan including payment of benefits provided by the Plan.

Investigational: See the definition of Experimental and/or Investigational.

Maximum Plan Benefits: The maximum amount of benefits payable by the Plan (and described more fully in each relevant section of this document) on account of covered expenses incurred by any covered Plan Participant. There are two types of plan maximums, described below:

Lifetime Maximum Plan Benefit is the maximum amount of benefits payable by the Plan during the entire time a Plan Participant is covered under this Plan. The Lifetime Maximum Plan benefits is often referred to as a "Lifetime" benefit, but this reference does not denote, nor should it be construed to denote, any obligation by the Plan to pay any benefits for the lifetime of the Plan Participant.

Annual Maximum Benefits are the maximum amount of benefits payable each Calendar Year or 12 months beginning with the date of last service, as appli-

cable on account of certain covered expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan.

Medically Necessary:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or by or under the direction of a Dentist if a dental service or supply is involved; **and**
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; **and**
   3. is determined by the Plan Administrator or its designee to meet **all** of the following requirements:
      • It is consistent with the symptoms or diagnosis and treatment of the illness or injury; **and**
      • It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; **and**
      • It is an **"Appropriate"** service or supply given the patient's circumstances and condition; **and**
      • It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; **and**
      • It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient, and is: as likely to result in information that could affect the course of treatment as; **and** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   2. It is care or treatment that is: as likely to produce a significant positive outcome as; **and** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

E. A medical or dental service or supply that can safely and Appropriately be furnished in a Physician's or Dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

F. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will **not** result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

G. A medical or dental service or supply will **not** be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc.

Nurse: A person legally licensed as a Registered Nurse (RN) Nurse Practitioner (NP), Licensed Practical Nurse (LPN), or any equivalent designation, under the laws of the state or jurisdiction where the services are

rendered, who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Orthodontics, Orthodontia: The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are not incurred.

Participant: see definition of Plan Participant.

Permanent and Total Disability: The welfare uses the determination of the Social Security Administration to define permanent and total disability.

Plan, This Plan: The programs, benefits and provisions described in this document.

Plan Administrator: The [person or legal entity] [Board of Trustees] who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: The employee or individual who has enrolled for coverage under the Plan. As used in this document, this term does not include the Spouse or Dependent Child(ren) of the Plan Participant.

Plan Year: The twelve-month period from July 1 to June 30 designated to be the Plan Year.

Professional Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part.

Retiree: Retiree is defined as a Welfare Fund participant having been actively employed at a unionized day care center and retiring from active employment from the day care center. A former participant is not eligible if she/he left active day care employment for any reason other than retirement and/or disability (as defined by Social Security Administration). Upon retirement from day care employment the participant/employee must be immediately eligible for a CIRS pension and meet the age and years of service requirements.

Spouse: The employee's lawful spouse as determined by the laws of the state where the covered employee or retiree resides. The Plan will require proof of the legal marital relationship. A legally separated spouse or divorced former spouse of an employee or retiree is not an eligible spouse under this Plan.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Subrogation and Right of Recovery section for more information.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with the Day Care Center as a result of a non-occupational illness or injury.

You, Your: When used in this document, these words refer to the employee who is covered by the Plan. They do not refer to any Dependent of the employee.

NOTES