

**DOCTORS COUNCIL BENEFIT PLAN C**

**BENEFIT BOOKLET**

**FIRST ISSUE JANUARY 1, 2005**

**DOCTORS COUNCIL BENEFIT PLAN (C) - PLAN OFFICE**

50 Broadway, 11th Floor, Suite 1101  
New York, New York 10004  
Phone (212) 532-5995 Facsimile (212) 481-4137  
welfarefund@doctorscouncil.com  
www.doctorscouncil.com

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The Board of Trustees can be reached at the Plan Office's address, set forth above. The name, title, and principal place of business of each member of the Board of Trustees follow:

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Doctors Council  
50 Broadway, 11<sup>th</sup> Floor, Suite 1101  
New York, New York 10017

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Trustee  
Doctors Council Benefit Plan  
Medical Associates of Woodhull, P.C.  
760 Broadway - 10<sup>th</sup> Floor  
Brooklyn, New York 11206

Surinder Patti, M.D.  
Delegate and Representative  
Doctors Council  
Coler-Goldwater Hospital/ RIMA  
1 Main Street, E Building, Lower Level  
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2601 Ocean Parkway  
Brooklyn, New York 11235

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Coler-Goldwater Hospital  
1 Main Street, E Building, Lower Level  
Roosevelt Island, New York 10044

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**PLAN COUNSEL**

Pryor, Cashman, Sherman & Flynn, LLP  
410 Park Avenue, 10th Floor  
New York, New York 10022

**PLAN AUDITOR**

Daniel E. Jelinsky  
Certified Public Accountant  
3 Regina Road  
Morganville, New Jersey 07751

**ACTUARIES AND CONSULTANTS**

The Segal Company  
One Park Avenue  
New York, New York 10016

Dear Member:

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

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

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

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

Sincerely,

Board of Trustees

## NOTICE OF CHANGES TO YOUR BENEFITS

December 2008

Dear Member:

The Board of Trustees has approved the following benefit changes which become effective January 1, 2009:

- **DENTAL BENEFIT INCREASES -  
See the attached revised dental fee schedules**

I. Whenever possible, please continue to utilize the **DOCTORS COUNCIL WEBSITE**, [www.doctorscouncil.com](http://www.doctorscouncil.com), to download benefit claim forms as well as the **Summary Plan Description for your Plans**.

II. We hope that you will continue to take advantage of the benefits offered by the Plan, and remind you that these benefits are provided at no cost to you. As always, should you have any questions or require assistance you may contact the Plan Office at 212.532.5995, by FAX 212.481.4137, or by mail to:

Doctors Council Benefit Plan  
50 Broadway, Suite 1101  
New York, New York 10004

**To request claim forms only, or to receive a copy of the benefit booklet, contact 212.532.5995 ext. 5 on your touch-tone phone and follow the instructions given. All requests are responded to within 48 hours.**

Yours truly,

The Board of Trustees

## TABLE OF CONTENTS

	<u>Page</u>
Introduction.....	1
Eligibility.....	2
Termination of Coverage.....	3
Family/Medical/Military Leave.....	4
Benefits Cost.....	5
Dependent Coverage .....	6
Coordination of Benefits .....	9
Claim Filing Procedures .....	12
Dental Benefit .....	13
Schedule of Dental Allowances .....	20
Healthcare Cost Reimbursement Benefit.....	21
Hearing Aid Benefit .....	23
Legal Services Benefit - In-State Residents .....	25
Legal Services Benefit - Out-of-State Residents.....	28
Optical Benefit .....	29
Physical Examinations .....	31
Self-Paid Continuation of Coverage (COBRA).....	33
Certificate of Creditable Coverage .....	42
Other Important Information .....	43

## INTRODUCTION

Benefits described in this booklet are for employees of the Doctors Council bargaining unit of Columbia University. Employees of the Downtown Bronx Medical Associates, P.C., Prison Health Services, Inc. and Roosevelt Island Medical Associates, P.C. are covered by Doctors Council Benefit Plan B. Employees of the Medical Associates of Woodhull, P.C. and University Group Medical Associates, P.C., are covered by Doctors Council Benefit Plan A.

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

- 1) **File your benefit claims on time.** The Doctors Council Benefit Plan C must receive the required documents postmarked no later than **one year (365 days)** from the date of service unless expressly indicated otherwise for a particular benefit. If you believe that your claim will be late, contact the Plan Office in writing **before the 365th day** after the date of service for further instructions;
- 2) Notify the Plan Office at once if there is a change in your family status.
- 3) Provide all information requested to prevent delay in processing your claim;
- 4) Review the description of benefits carefully, especially benefit exceptions and exclusions;
- 5) Read all information sent to you by the Plan Office and respond to all requests in a timely fashion.

## **MEMBER ELIGIBILITY**

### Eligibility Requirements:

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

Columbia University in the Doctors Council bargaining unit and are employed twenty (20) hours or more per week.

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

## **TERMINATION OF COVERAGE**

Coverage ends when you leave employment with the Employer or are employed less than twenty (20) hours per week. Dependent coverage continues for 30 days after the death of the member.

Please turn to the section of this booklet entitled "Self-Paid Continuation of Coverage (COBRA)" on page 42 for details on how you can continue coverage for yourself and/or your dependents.

## FAMILY/MEDICAL/MILITARY LEAVE

This section includes the following:

- Family and Medical Leave
- Military Leave

### Family and Medical Leave:

If you are entitled by law to up to 12 weeks of unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill, or for your own serious illness, you can continue your medical coverage during that leave period. Your Employer is required to continue to pay your contributions for that coverage during the period of that leave. If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation Coverage, as outlined on page 42.

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

### Military Leave:

If you go into active military service for up to 31 days, you can continue your medical coverage during such leave period. Your Employer must continue to pay your contributions for coverage during such period of leave.

If you lose eligibility because of your induction into the Armed Forces, you will be reinstated for benefits as of the date of your re-employment with a contributing Employer, provided that you secure such employment within one year of your discharge from the service or within one year of hospital discharge if you are hospitalized at the time of your separation from the service. If you are called into active military service for more than 31 days, you may be able to continue your coverage at your own expense for up to 18 months through COBRA Continuation Coverage (see page 42).

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

## BENEFIT COST

The benefits described in this booklet are provided without cost to you as the primary beneficiary. If you have a benefit(s) covered under this Plan that is also provided for through your Employer, then this Plan shall be supplemental to that primary insurance. *The Employer pays the entire cost through contributions under the Doctors Council collective bargaining agreement.* The contributions for these benefits do not come from payroll deductions. When your dependents cease to be eligible for benefits, you or they must contact the Plan Office for information about continuation of benefits on a self-paid basis. See COBRA Continuation Coverage (page 42).

## DEPENDENT COVERAGE

This section include the following:

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

### Dependent Eligibility:

Your spouse or domestic partner and dependents up to the age of 19 (up to age 26 if they are full-time students) are eligible for some of the benefits provided by this Plan. Reference to covered members' dependents means those spouses and children/grandchildren of the member who qualify as dependents under the Internal Revenue Code, and domestic partners determined by the Plan Office to be eligible to receive domestic partner benefits from the Plan. Dependent children who, regardless of age, are unable to support themselves due to mental illness, developmental disability, mental retardation, or physical handicap, provided such incapacity occurred before age 19, are also considered eligible dependents by this Plan. See the description of each benefit for complete information.

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

domestic partners. You are advised to review the consequences of electing this benefit with your own tax advisor.

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

#### Qualified Medical Child Support Orders (QMCSO):

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

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

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

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

### Extension of Dependent Coverage:

Dependent coverage continues for 30 days without cost only after the death of the member. For coverage beyond 30 days after the death of the member and for coverage after divorce, or after legal separation, or when a dependent doesn't meet qualifications see COBRA Continuation Coverage (page 42).

### Changes in family status or family circumstance:

- The Plan Office should be notified promptly when any change occurs in your family status such as: marriage, divorce, separation, termination/initiation of domestic partnership, birth or adoption of a child, death of the member, death of an eligible dependent or you wish to change the beneficiary of your life insurance benefit. The Plan must be notified within 30 days of the change.
- The member or eligible dependents should notify the Plan Office within 30 days from the date of any change of name and/or address.
- For dependent(s) for whom you have formerly declined enrollment because of other health insurance coverage, you may enroll these dependent(s) in the Plan within 30 days from the date the other insurance coverage ceases.
- The Plan should also be notified promptly of any change in employment status or leave of absence which may entitle you to continuation of coverage.

## COORDINATION OF BENEFITS

This section includes the following:

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

### Definition of Coordination of Benefits:

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

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

You may be covered as a dependent under your spouse's Plan in addition to being covered under this Plan, or your dependents may be covered under both Plans.

### Determination of Benefit Payments:

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

- The Plan without a coordination of benefits provision.
- Where both Plans have a coordination of benefits provision, the Plan that covers a person as a member, rather than as a dependent.
- If you and your spouse are both covered as employees by the Doctors Council Benefit Plan C, you will receive payment first as an employee and second as a dependent.

- In the case of a dependent child, the Plan of the parent whose birthday occurs earlier in a calendar year pays first. If both parents have the same birthday, the Plan which has covered the parent longer will pay first.
- If you are separated or divorced, there are special rules regarding coverage for your children. If a court order establishes responsibility for the health care expenses of your children, benefits are paid according to that order. If there is no court order, benefits are paid in the following order:
  - 1) The Plan of the parent/stepparent having custody of the child.
  - 2) The Plan of the parent/stepparent not having custody of the child.

### Medicare:

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

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

### Medicare and End-Stage Renal Disease:

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

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

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

period of 33 months. Beginning with the **34th month**, Medicare will pay first and this Plan will pay second.

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

## CLAIM FILING PROCEDURES

This section includes the following:

- Claim Filing Procedure
- Claim Review

### Claim Filing Procedure:

The procedure for filing claims depends on the benefit. Please see the explanation following each benefit for the correct procedure to follow.

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

- Healthcare Cost Reimbursement Benefit Claims: **Must be postmarked no later than March 31<sup>st</sup> in the year following the end of each Plan Year (December 31<sup>st</sup>).**

### Claim Review:

There is a claim review procedure to follow if your claim for a benefit is denied. See page 53 for details.

## DENTAL BENEFIT

(revised effective July 1, 2002)

This section includes the following:

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

### Benefit Description:

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

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

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

Maximum Benefit Per Person per lifetime for Orthodontic Coverage (for Dependent Children Only) is \$3,150.

All dental reimbursement is in accordance with the schedule on page 22.

### Filing a claim:

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

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

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

### Filing Deadline:

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

### Choosing a Dentist:

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

### Participating Dentist Program:

The Participating Dentist Program is designed to provide you with comprehensive dental care services while reducing or eliminating your out-of-pocket expenses. Participating dentists will accept the amounts shown in the Schedule of Dental Allowances as payment in full for services that are listed in the Schedule of Dental Allowances (found on page 23 of this booklet) **with the following exceptions:**

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

- For services rendered by a non-participating provider, such as an anesthesiologist, in conjunction with, or as part of, the treatment or services rendered by the participating dentist;
- For non-covered services, i.e., services not listed in this booklet and/or indicated under non-covered services in this section. If a dental service is performed for a condition that is not listed in the Schedule, but alternative treatments are listed, your dental Plan may pay a benefit based on the listed service that would produce a professionally satisfactory result charges generally exceed the dental Plan allowances listed in the Schedule of Dental Allowances, using a participating dentist for treatment will represent an overall savings to you in the cost of your dental services.

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

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

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

#### Using a non-Participating Dentist:

If you choose to seek treatment from a non-participating dentist, the Plan will reimburse you up to the maximum allowance set forth in the Schedule of Dental Allowances which begins on page 22, in accordance with the Plan's limitations and exclusions (see non-covered services in this section). If the non-participating dentist charges less than the Schedule allows, you will be reimbursed for the actual

amount of your bill. If your dentist charges more than the schedule allows, you will be reimbursed for the scheduled amount and you will be responsible for the balance of the charge yourself.

When you receive treatment from a non-participating dentist, the Doctors Council Benefit Plan does not assign benefits – that is, payment is made to the member only.

#### Pre-treatment Plan:

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

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

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

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

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

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

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

Please be aware that a pre-treatment authorization is not a promise of payment. Work must be done

while you are still covered by the Plan for benefits (except where there is an Extension of Benefits as described above) and no significant change can have occurred in the condition of your mouth after the pre-estimate was issued and prior to the work. Payment will be made in accordance with Plan allowances and limitations in effect at the time services are provided.

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

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

**Alternate Benefit Provision:**

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

**Non-covered dental services:**

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

- Procedures performed by a patient's immediate family (mother, father, son, daughter, spouse, domestic partner, brother or sister) with the exception that coverage will be provided for fees for laboratory services related to fixed and removable prostheses, which would include full dentures, partial dentures, crowns, bridges, castings, inlays and bite plates,
- Procedures or supplies not listed in the dental schedule,
- Services and supplies not furnished by a dentist, except X-rays ordered by a dentist and the services of a licensed dental hygienist performed under a dentist's supervision;

- Services provided by the U.S. government or any other government, for which payment is not required of the member;
- Surgical and prosthetic aspects of implants except as noted in the Schedule of Dental Allowances. Payment will be made only for conventional restoration of the mouth;
- Services resulting from an automobile accident covered by No-Fault insurance;
- Services caused by war or an act of war or while serving in the military;
- Cosmetic services unless made necessary because of an accident while the member is covered;
- Orthodontia for member, spouse or domestic partner;
- Services resulting from a work-related accident or disease covered by Workers' Compensation;
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the temporomandibular joint;
- Multiple bridge abutments.

#### Implantology:

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

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

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

#### Dental Benefit Extension:

The Dental Plan has a provision for extension of your benefits in the event your coverage in the Plan ceases. Coverage for certain dental services commenced or approved prior to termination of your

general eligibility for Plan benefits will continue for 30 days after the date your other coverage ends. The extensions are detailed below.

Benefits are extended for:

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

For dental benefit extension beyond 30-days see COBRA Continuation Coverage page 33.

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefits provision, please see page 9.

<u>DIAGNOSTIC &amp; PREVENTIVE</u>	Scheduled Allowance	<u>PERIODONTICS</u>	Scheduled Allowance
ORAL EXAM	50.00	PERIODONTAL TREATMENT	
FULL MOUTH SERIES	120.00	Root scaling, subgingival curettage, bite correction, including propl	
PANORAMIC X-RAY	120.00	Per visit	70.00
PA or BW X-RAY	10.00	Full mouth	80.00
OCCLUSAL FILM	30.00	OCCLUSAL ADJUSTMENT – COMPLETE	80.00
EXTRA ORAL or TMJ FILM	34.00	PERIODONTAL SURGERY	
CEPHALOMETRIC FILM	60.00	Gingivectomy or gingivoplasty, delivery of	
PROPHYLAXIS – ADULT	80.00	Chemotherapeutic agents, soft tissue graft	
PROPHYLAXIS – CHILD	40.00	Vestibuloplasty, any combination, per quad	150.00
SPACE MAINTAINER – ACRYLIC	101.00	OSSESIOUS SURGERY	450.00
SPACE MAINTAINER – METAL	250.00	OSSESIOUS GRAFT - SINGLE SITE	65.00
FLUROIDE	35.00	OSSESIOUS GRAFT – MAX PER JAW	325.00
SEALANT	35.00	GUIDED TISSUE REGENERATION	275.00
DIAGNOSTIC CASTS	30.00		
<u>RESTORATIVE</u>		<u>ORAL SURGERY</u>	
SILVER AMALGAMS		ROUTINE EXTRACTION	95.00
One surface	80.00	SURGICAL EXTRACTION	
Two surface	100.00	Erupted tooth	200.00
Three surfaces	125.00	Impaction – soft tissue	175.00
Four or more surface	125.00	Impaction – partial bony	300.00
PLASTIC or SILICATE FILL	30.00	Impaction – complete bony	400.00
COMPOSITE RESIN - 1srf anterior	100.00	CYST REM OVAL	70.00
COMPOSITE RESIN - 2srf anterior	115.00	ALVEOLOPLASTY – per quad	100.00
COMPOSITE RESIN - 3 or more surfaces anterior	145.00	INCISION AND DRAINAGE	50.00
RESIN – INCISALANGLE	175.00		
COMPOSITE RESIN - 1srf posterior	100.00	<u>DENTURES</u>	
COMPOSITE RESIN - 2srf posterior	140.00	COMPLETE DENTURE	
COMPOSITE RESIN - 3srf posterior	160.00	Immediate or permanent	750.00
PIN RETENTION	25.00	PARTIAL ACRYLIC BASE	475.00
METALLIC INLAY - 1srf	150.00	UNILATERAL – one tooth	325.00
METALLIC INLAY - 2srf	400.00	PARTIAL – CAST METAL BASE	650.00
METALLIC INLAY - 3srf	500.00	TISSUE CONDITIONING	70.00
PORCELAIN INLAY - 1srf	168.00	PRECISION ATTACHMENT	325.00
PORCELAIN INLAY - 2srf	400.00	DENTURE REPAIRS	
PORCELAIN INLAY – 3srf	500.00	Broken denture base	75.00
COMPOSITE INLAY – 1srf	95.00	Replace tooth in denture	75.00
COMPOSITE INLAY – 2srf	125.00	Replace broken facing	95.00
COMPOSITE INLAY – 3srf	300.00	Add or replace clasp	75.00
CAST POST & CORE	200.00	Reattach clasp	65.00
PER-FAB POST & CORE	175.00	Add tooth to existing partial	110.00
LAMINATE VENEER - LAB	450.00	DENTURE ADJUSTMENT	40.00
		DENTURE RELINE	
<u>CROWNS &amp; BRIDGES</u>		Partial – office	100.00
CROWNS		Complete – office	135.00
Acrylic jacket (lab)	193.00	Partial or complete – lab	175.00
Stainless steel (primary tth)	67.00	BRIDGE PONTICS	
Porcelain jacket	600.00	Full cast	500.00
Plastic with metal	425.00	Plastic with metal	425.00
Porcelain with metal	600.00	Porcelain with metal	550.00
Full cast	550.00	ENDOSSEOUS IMPLANT	1200.00
¾ cast	400.00	SUBPERIOSTEAL IMPLANT	1200.00
RECEMENTATION		CROWN OVER IMPLANT	1200.00
Of crown or inlay	50.00	ABUTMENTS	
Of bridge	85.00	Inlay – 2 surface	400.00
		Inlay – 3 surface	500.00
<u>ENDODONTICS</u>		Plastic with metal	425.00
PULP DIRECT – direct	50.00	Porcelain with metal	600.00
PULP CAP – indirect	35.00	Full cast	375.00
VITAL PULPOTOMY	110.00	¾ cast	400.00
ROOT THERAPY		Maryland bridge retainer	175.00
One canal	400.00		
Two Canals	500.00	<u>ORTHODONTICS</u>	
Three Canals	550.00	DIAGNOSIS & INTIAL INSERTION	1250.00
Four canals	625.00	ACTIVE TX – per mouth	120.00
APICOECTOMY – 1 <sup>ST</sup> root	250.00	POST-TREATMENT STABILIZATION DEVICE	225.00
APICOECTOMY – maximum per tooth	390.00	PASSIVE TX – per 3 months	120.00
RETROGRADE ROOT FILL – per root	70.00		
ROOT RESECTON	175.00	<u>ADJUNCTIVE SERVICES</u>	
ROOT THERAPY – RETREATMENT		GENERAL ANESTHESIA/ IV SEDATION	200.00
One canal	600.00	CONSULTATION	85.00
Two canals	750.00	PALLIATIVE TREATMENT	45.00
Three canals	825.00	ANALGESIA	25.00
		APPLICATION OF DESENSITIZING AGENT	20.00
		BRUXISM APPLIANCE	275.00

## HEALTHCARE COST REIMBURSEMENT BENEFIT

(effective January 1, 2005)

This section includes:

- Benefit Description
- Covered Services
- Filing Procedure

### Benefit Description:

Member, spouse or domestic partner and eligible dependent children are entitled to reimbursement expense every Plan year (January 1 - December 31) for a maximum of \$300 per family.

### Covered Services:

The following services are covered:

- 1) Medical and Hospital deductibles and co-payments under Medicare and/or your group medical/surgical and hospital insurers;
- 2) Prescription drug deductibles and co-payments under your group medical/surgical and hospital insurers;
- 3) Charges incurred for health services covered in a member's existing coverage that exceed the reimbursement received, including services covered under Doctors Council Benefit Plan;
- 4) Premiums for Medicare Part "B", Medigap, and other out-of-pocket healthcare expenses.

### Filing Procedure:

To file a claim for this benefit, obtain a claim form from the Plan Office. Complete the claim form and attach all Explanation of Benefit Statements and itemized bills. **Do not submit your claim until the end of the Plan Year unless you have already met the full amount of the benefit. All**

**claims for the benefits for the Plan Year ending December 31 must be postmarked by March 31.**  
Only one claim per member per Plan year should be submitted for the Plan to process.

## HEARING AID BENEFIT

This section includes the following:

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

### Benefit Description:

Under this benefit, a member and spouse or domestic partner are eligible for reimbursement once every two years for the purchase, repair and maintenance of hearing aids (batteries are not included) and for a hearing examination not covered by Medicare or any other insurance.

Member or Spouse or Domestic Partner, per person.....\$900.00

**Hearing aids are available for both ears if prescribed.**

### Covered Expenses:

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

### Exclusions:

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

### Filing Procedure:

Obtain a claim form from the Plan Office. Take this form with you when you go for an appointment. Complete the member's portion and have your physician complete the physician's portion. Attach the itemized bill for the hearing aid to this form, and return it to the Plan Office postmarked within one year from the date the services were rendered. **Claims postmarked more than one year from the**

**date the services were rendered will not be considered for payment.** The bill must be itemized and describe the appliance purchased, the amount charged, the name of the person who required the hearing appliance, and the Otologist's or Otolaryngologist's authorization or certification.

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

Coordination of Benefits:

Please remember that this benefit is coordinated with any other coverage you may have. For a complete description of your coordination of benefit provision, please see page 10.

## LEGAL SERVICES BENEFIT

### New York State Residents

(revised effective October 1, 2007)

This section includes the following:

- Benefit Description
- Exclusions
- Filing Procedure

#### Benefit Description:

The legal services covered by the Plan are limited to those which can be provided by lawyers admitted to practice in the state of New York. The law firm of Pryor, Cashman, Sherman and Flynn, 410 Park Avenue, New York, New York 10022 has been retained for the purpose of providing the legal services benefit, and all matters will be handled confidentially on an attorney-client basis. Each covered doctor is responsible for reimbursing the law firm directly for expenses (e.g., toll calls, photocopies, transportation, filing fees, etc.) for services performed on behalf of the doctor or his/her spouse or domestic partner. No expense over \$50 will be incurred without the doctor's prior knowledge and approval. The law firm will require payment of an advance against disbursements for expenses and legal fees of up to \$2,500 for all matters other than litigation, for which the advance may be up to \$5,000.

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

#### REAL ESTATE:

The purchase, sale or financing of a private or two-family residence owned by a covered doctor individually or jointly with another family member and used as the member's primary residence is covered at a fee of \$375; in the event of a second purchase, sale or financing within two years of the closing of the first transaction under the Plan, a fee of \$700 will be payable; for a third or subsequent transaction within two years of the closing of the first transaction under the Plan, a fee of \$1,000 will be payable. For example, a member selling one residence and purchasing

another any time within two years of the closing of sale would pay a fee of \$375 for the first transaction and \$700 for the second transaction.

- MATRIMONIAL: An uncontested divorce involving a covered doctor;
- ADOPTION: An uncontested adoption, where a covered doctor is an adoptive parent;
- NAME CHANGE: A change of name of a covered doctor, spouse/domestic partner or dependent;
- CRIMINAL DEFENSE: Defense in a criminal prosecution, up to and through the point of arraignment, for a covered doctor, spouse or domestic partner;
- GENERAL  
CONSULTATION/  
REPRESENTATION: In each Plan year, two hours of general consultation (without charge to the participant) or other legal services on behalf of a covered doctor, spouse or domestic partner concerning any legal matter (without charge to the participant), except those covered under the Plan on a contributory basis or excluded below, and up to fifty (50) additional hours at a reduced hourly rate of \$150 (payable by the covered doctor);
- ESTATE  
ADMINISTRATION: In each Plan year, probate of an uncontested estate of a member or his/her spouse or domestic partner, parents, children or grandparents, and/or the processing of a claim pertaining to an estate on behalf of a covered doctor and/or spouse or domestic partner, including five (5) hours of service without charge to the member and up to twenty-five (25) additional hours at a reduced hourly rate of \$150 (payable by the covered doctor);
- ESTATE PLANNING: Drafting and settlement of a will or codicil (any amendment to a will) for a covered doctor, spouse or domestic partner at a single charge of \$350 to the doctor; a \$650 fee covers services for **both** the eligible doctor and spouse or domestic partner, provided that the estate Planning and

preparation and execution of the wills are undertaken concurrently; in the case of complex estate planning, documents (other than the will or codicil, power of attorney and health care proxy) such as an insurance trust, inter vivos trust or a real estate transfer related to estate planning will be prepared for an additional charge of \$300 per document;

PERSONAL INJURY: Personal injury and property damage actions on behalf of a covered doctor and his/her dependents at a contingency fee of 25% of any recovery; the legal service provider reserves the right to reject proceeding on a contingency fee basis.

Exclusions:

The following matters are not covered under this Plan:

- Matters involving controversy or a conflict with the *Employer or otherwise arising out of your employment under* a Doctors Council contract, except for a proceeding initiated by a State administrative agency which may result in the suspension or revocation of a member's license; and
- Legal services required in any matter not specifically stated above over fifty (50) hours. Upon the exhaustion of fifty (50) hours of legal services, the member may, at his or her option, retain the firm at its regular rates or obtain other counsel.

Filing Procedure:

You must call the Plan Office directly at (212) 532-5995. The Plan Office will then determine whether you are a covered doctor and advise the law firm accordingly or send you the appropriate reimbursement forms if you participate in the out-of-state LSP. If you participate in the in-state LSP the Benefit Plan employee will not ask you about the nature of the matter.

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

## LEGAL SERVICE BENEFIT

### Out-of-State Residents

This section includes the following:

- Benefit Description
- Filing Procedure
- Filing Deadline

#### Benefit Description:

**Members who reside outside of the State of New York will be enrolled in the Out-of-State Legal Services Plan unless they express their wishes in writing to join the In-State Legal Services Plan.**

In order to choose the In-State LSP, a member must notify the Plan Office prior to the beginning of the new fiscal year (January 1) that he/she wishes to be a participant in the In-State LSP for the coming year, and until further notice.

The out-of-state LSP provides up to \$200 reimbursement for fees paid for either the preparation of a will for member or spouse/domestic partner OR a real estate closing (restricted to personal residence of member or spouse/domestic partner) or the refinancing of a mortgage once each Plan Year (January 1 -December 31).

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

#### Filing Procedure:

You must call the Plan Office directly at (212) 532-5995. The Plan Office will then determine whether you are a covered member and send the appropriate reimbursement forms if you participate in the out-of-state LSP.

#### Filing Deadline:

**Claims postmarked more than one year after the date service is rendered will not be considered for payment.**

## OPTICAL BENEFIT

This section includes the following:

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

### Benefit Description:

Member, spouse or domestic partner and eligible dependent children are each entitled to reimbursement once every Plan Year (January 1 - December 31) for prescription eyeglasses, contact lenses and eye examinations to a maximum of \$250 per person.

### Exclusions:

Exclusions under this benefit are:

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

Claim Filing Procedure:

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

Coordination of Benefits:

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

For a complete description of your coordination of benefits provision, please see page 10.

## **PHYSICAL EXAMINATIONS**

### **Benefit Description:**

Members, spouses and domestic partners are covered once a year for a physical examination, which includes laboratory tests. The Affiliated Physicians office, which is located at 18 East 48<sup>th</sup> Street, 2<sup>nd</sup> Floor, New York, New York 10017, will provide the examination.

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

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

**A \$50.00 no-show fee is assessable to the member if an appointment is not canceled at least 48 hours prior to the confirmed time.**

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

The exam will include all of the following:

Complete Personal and Family History

Physical Examination Of All Body Systems

X-ray of the Heart and Lungs

12 Lead Resting Electrocardiogram with complete interpretation

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

Eye Tests by Ortho-rater

Near and Distant Vision

Color Vision

Tonometry for Glaucoma

Thyroid Function Test

Pap smear

PSA

Complete pulmonary function analysis

Proctosigmoidoscopy (Instrumental examination of the rectum and lower bowel, with flexible fiberoptic sigmoidoscope – available once every 2 years)

Stool test for occult blood (3 slides)

SMAC blood chemistry analysis

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

Cholesterol Fractionation, for coronary risk evaluation:

HDL (High Density Lipoprotein)

LDL (Low Density Lipoprotein)

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

## SELF-PAID CONTINUATION OF COVERAGE

### (COBRA)

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

This section includes the following:

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

#### Benefit Description:

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

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

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

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

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

### COBRA Continuation Coverage:

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

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

### *Acquiring a New Dependent during the COBRA Continuation Coverage Period:*

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

### *Loss of Other Group Health Plan Coverage:*

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

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not

include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 30 days after the termination of the other coverage. Adding a dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage.

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

#### Initiating COBRA Continuation Coverage:

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

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

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

- (4) When a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA Continuation Coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA Continuation Coverage.
- (5) When the Social Security Administration determines that a Qualified Beneficiary is no longer disabled.

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

#### *How Should A Notice Be Provided?*

Notice of any of the five situations listed above must be provided in writing. You may send a letter to the Plan Office containing the following information: your name, the event listed above of which

you are providing notice, the date of the event, and the date on which the participant and/or beneficiary will lose coverage.

#### *When Should the Notice Be Sent?*

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

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

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

#### *Who can Provide a Notice?*

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

Your employer should notify the Plan Office of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also notify the Plan Office promptly and in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Plan Office.

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

### Self-Paid Premium:

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

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

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

### Termination of COBRA Continuation Coverage:

COBRA Continuation Coverage will terminate on the earliest of:

- Failure to pay the required premium on time;
- The date the individual becomes covered under another Employer-funded group health Plan either as an employee or dependent unless the individual has a pre-existing condition which the other Plan will not cover. In that event the individual (and eligible dependents) may be allowed to continue his or her COBRA Continuation Coverage for the applicable maximum period or wait until the other Plan's pre-existing condition exclusion no longer applies to that individual. Contact the Plan Office for details.
- The date the individual becomes enrolled in Medicare (except in the case of a Medicare-entitled spouse of a deceased member). However, the individual's non-Medicare-entitled dependents can continue coverage for up to 36 months from the date of the individual's Medicare entitlement.
- The date the group health Plan terminates as to the eligible group of which you were a member. If the coverage is replaced, your coverage will be continued under the new Plan.
- 18 months (maximum) from the Qualifying Event if coverage is being continued for an employee, spouse or dependent because the employee ceased covered employment or lost eligibility due to reduced hours. This may be extended to 29 months (maximum) in the case of

a determination of disability by the Social Security Administration. See “Entitlement to Social Security Disability Income Benefits” on page 49.

- 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or dependent for a reason other than the employee’s loss or reduction of employment, including the participant’s Medicare entitlement.
- Full details of COBRA Continuation Coverage will be furnished to you or your dependents when the Plan Office receives notice that one of the Qualifying Events has occurred. **Therefore, we urge employees and dependents to contact the Plan Office as soon as possible after one of those events.**

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

Entitlement to Social Security Disability Income Benefits:

If you, your spouse or any of your covered dependents are entitled to COBRA –Continuation Coverage for an 18-month period, that period can be extended for a covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if:

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

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

## Second Qualifying Events:

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

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

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

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

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

Confirmation of Coverage:

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

**KEEP THE PLAN INFORMED OF ADDRESS CHANGES**

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

## CERTIFICATE OF CREDITABLE COVERAGE

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

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

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

Plan Administrator  
Doctors Council Benefit Plan C  
50 Broadway, 11<sup>th</sup> Floor, Suite 1101  
New York, NY 10004  
(212) 532-5995

## OTHER IMPORTANT INFORMATION

### **This section includes:**

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

The date of these procedures is January 1, 2005. This supersedes any prior version.

### **Claims and Appeals Procedures**

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

#### **How to File a Claim**

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

Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

A claim form, for use with all benefits, may be obtained from the Plan Office by calling: (212) 532-5995

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

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

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

### **When Claims Must Be Filed**

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

- Legal Services Benefit requires that you call the Plan Office first to verify eligibility.
- Healthcare Cost Reimbursement Benefit claims must be postmarked by March 31 in the year following the end of the Plan Year (December 31).

### **Where To File Claims**

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

For Hearing Aid, Legal Services, and Optical Benefits, please mail claims to/obtain pre-certifications from:

Doctors Council Benefit Plan C  
 50 Broadway, 11<sup>th</sup> Floor, Suite 1101  
 New York, New York 10004  
 (212) 532-5995 (telephone)  
 (212) 481-4137 (fax)

For Dental Benefits, please mail claims to:

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

For Healthcare Cost Reimbursement Benefits, please mail claims to:

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

## Authorized Representatives

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

## Claims for Benefits

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

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

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

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

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for covered services to the Plan or SIDS as soon as you receive them.

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

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

### **Notice of Decision**

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

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

### **REQUEST FOR REVIEW OF DENIED CLAIM**

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the organization that first reviewed the claim, either the Plan or SIDS, within *180 days* after you receive notice of denial.

### **Review Process**

The review process works as follows:

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

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

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

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who did not take part in the adverse benefit determination (and is not subordinate to any individual who did) and who has appropriate training and experience in a relevant field of medicine will be consulted.

### **Timing of Notice of Decision on Appeal**

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

### **Notice of Decision on Review**

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

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

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

## **Limitation on When a Lawsuit May Be Started**

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. You may also pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

### ERISA Required Statement of Rights:

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

#### Receive Information About Your Plan and Benefits:

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

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

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

#### Continue Group Health Plan Coverage:

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

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months

after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

#### Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

#### Enforce Your Rights:

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

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

#### Assistance with Your Questions:

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

#### HIPAA Privacy Rights:

Effective April 14, 2004, the Plan is subject to the requirements of the Health Insurance Portability and Accountability Act's regulations concerning the privacy of individually identifiable health information (commonly referred to as the "Privacy Rule"). The Privacy Rule requires the Plan to

provide participants with a notice containing a description of the Plan's potential uses and disclosures of protected health information, their rights and the Plan's legal duties with respect to such information, as well as other specific information. The notice must also be provided upon request, and within 60 days of a material revision to the notice. If you wish to request a copy of the notice or you have any questions regarding the Privacy Rule, please contact the Plan Office. This statement is not intended and cannot be construed as the Plan's required privacy notice.

Plan Amendments or Termination:

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

Discretionary Authority of the Plan Administrator and its Designees:

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

No Liability For the Practice of Medicine:

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

Additional Information:

The information in this booklet contains only a summary of the features of your coverage. This booklet is not a contract. The Plan is maintained pursuant to one or more collective bargaining

agreements. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Office, and is available for examination by participants and beneficiaries, as required by applicable law. Participants and beneficiaries may receive from the Plan Office, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

Plan Sponsor:	Board of Trustees of the Doctors Council Benefit Plan
EIN Number Assigned by the Internal Revenue Service:	13-3387038
Official Name of the Plan:	Doctors Council Benefit Plan
Plan Number:	501
Plan Administrator:	Board of Trustees of the Doctors Council Benefit Plan 50 Broadway, 11 <sup>th</sup> Floor, Suite 1101 New York, New York 10004 (212) 532-5995
Agent for Service of Legal Process:	Plan Administrator, at the address set forth above. Service of legal process may also be made upon a Plan trustee at the same address.
Type of Plan:	Welfare Benefit Plan providing supplemental dental, optical, hearing aid, as well as legal services benefits.
Type of Administration:	Self-insured: dental benefits are administered by Self Insured Dental Services (SIDS) under contract.
Trust Fund:	The assets of the Plan are held in a trust fund established and maintained under the Agreement and Declaration of Trust of the Doctors Council Benefit Plan.
Plan Year:	January 1 - December 31