DAY CARE COUNCIL/CSA

WELFARE FUND

HEALTH BENEFITS PROGRAM

JULY 1, 2004 EDITION

While this booklet describes the general features of the Day Care Council/CSA Welfare Fund program for your information, it is not to be deemed a contract of insurance. The specific terms and conditions governing your coverage are set forth in the certificates of each basic plan. Where a specific program is not covered by insurance, your benefit programs are controlled by the rules and regulations of the Day Care Council/CSA Welfare Fund then in effect.

WELFARE FUND

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MESSAGE FROM THE CHAIRMAN OF THE BOARD OF TRUSTEES

Dear Member:

You, the members, and we, the Trustees of the Day Care Council/CSA Welfare Fund, can look back upon years of accomplishment and take great pride in the range of benefits now available which are described in this new booklet.

We believe that we as Trustees have used our resources responsibly to meet the needs of those for whom the Fund was created. From meager beginnings, programs have been expanded to meet a wide variety of the needs of the members and their families in this era of rising health costs. The health benefits described in this booklet meet the difficult and arduous challenges of the past, the present and the future.

It is important that you read this booklet carefully so that you will be fully informed about the benefits provided by your Welfare Fund. Failure to inform yourselves fully about the benefits available to you can only result in a loss to you in your efforts to meet the needs of you and your family.

On behalf of the Trustees, we wish you and your families the best of health now and in the years to come.

Sincerely yours,
Kenneth G. Haag
Chairman
Board of Trustees

GREETINGS FROM THE PRESIDENT OF CSA

Dear Colleague:

This 2004 edition of your Day Care Council/CSA Welfare Fund booklet represents still another significant extension of the many benefits that our union provides. Since this Fund was established on January 1, 1980, we have been able to secure constant increases in the contributions made to the Fund. These increases have enabled your Trustees to substantially increase the benefits available to you and your dependents.

Our efforts have achieved for you and your dependents:

- a comprehensive dental benefit program offering a choice of coverage,
- a prescription drug plan that meets both long term and acute drug needs,
- an optical benefit program that covers all necessary services,
- a hearing aid benefit every three years,
- a life insurance benefit to provide peace of mind to your survivors, and
- a comprehensive major medical benefit program designed to supplement and expand your basic employer provided coverage.

We are proud of our accomplishments and pledge to you our continued efforts to provide you with the best possible coverage with the funds made available to us.

Sincerely,
Jill Levy
President

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WHO IS COVERED

ACTIVE MEMBERS

All Directors, Assistant Directors, Family Day Care Coordinators and Family Day Care Directors employed at participating Day Care Centers and for whom contributions are made to this Fund by such Centers are covered. A participating center is one which is covered under the collective bargaining agreement between the Council of Supervisors and Administrators Local 1 AFSA and the Day Care Council and the Administration for Child Services / Agency for Child Development.

DEPENDENTS

Coverage for Dependents is a member benefit and is provided at the request of the member. Eligible dependents of covered members are fully covered for Welfare Fund benefits, except for life insurance benefits. Dependents as defined by the Welfare Fund are the legally married spouse (or registered domestic partner) eligible for coverage by the employer-provided health benefits program (Blue Cross/GHI or HIP-HMO); unmarried dependent children who have not reached their 19th birthday, and unmarried dependent children who are full-time students and have not reached their 23rd birthday. Dependent coverage is also extended to any unmarried child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so prior to attainment of age 19 and is wholly dependent on the covered member for support. Members must submit proof of a dependent child's incapacity to the Fund Office 31 days before the date he/she attains the age

at which his/her coverage would otherwise terminate. In addition, evidence must be provided to the Fund that the disabled dependent child has been approved for continued coverage by the employer-provided basic hospital/medical (Blue Cross/GHI or HIP/HMO) plan. Proof of the continued existence of such incapacity shall be furnished to the Fund from time to time at its request.

RETIRED MEMBERS

Participants who retire under the Cultural Institutions Retirement System and their eligible dependents may continue to remain covered for retiree benefits provided they contribute directly to the Fund an annual contribution as determined by the Trustees. The first year's payment is to be made (in full) in advance. Subsequent years' payments are to be made quarterly in advance. The Fund should be contacted regarding the amount of money due.

Retirees may authorize the Cultural Institutions Retirement System to deduct their monthly Welfare Fund contribution from their monthly pension check and to remit this contribution to the Fund on their behalf.

Application to the Fund for continued coverage as a retiree must be made within 12 months from the date of retirement.

Retiree benefits are described in a separate section of this booklet.

Retirees who fall in arrears will lose their membership in the Fund. Once membership has been terminated it can not be reinstated.

INITIAL ELIGIBILITY

All new employees and their covered dependents become eligible for all benefits provided by the Fund on the first day of the month following the

month in which the employee completes 30 days on payroll.

TERMINATION OF COVERAGE FOR MEMBERS

All benefits for active members will terminate on the last day of the month in which the member fails to be on the payroll for 30 continuous days. Transfer from one covered Day Care Center to another will not be considered as terminating covered employment, and eligibility will continue uninterrupted.

Transfers from one eligible position to another will be interpreted similarly.

All benefits for retired participants will terminate on the first day of the month for which the retiree has not made advance payments.

TERMINATION OF COVERAGE FOR DEPENDENTS

Coverage for dependents will terminate upon the earliest to occur of the following:

- The date on which the member's coverage terminates
- The date on which the dependent fails to meet the criteria as a dependent under the plan
- The date the member requests that a dependent's coverage be terminated

REINSTATEMENT –LEAVE WITHOUT PAY –VOLUNTARY

All active participants who voluntarily leave covered employment for more than one year must again meet the plan's initial eligibility rules, All active participants who voluntarily leave covered employment for less than one year will be reinstated with full plan benefits on the first day of the month following the month the employee returns to payroll.

CONTINUATION OF BENEFITS

All active participants who exhaust their sick leave benefits and are on a "leave without pay for reasons of health" will have their benefits continued for three months after the month in which they were last on payroll.

COORDINATION OF BENEFITS

All Benefits provided by the DCC/CSA Welfare Fund are subject to Coordination of Benefits (COB) provisions. COB is applicable when you or your dependent is covered by another group benefit plan. Benefits are then payable under a Primary-Secondary formula.

The Primary Plan determines its benefits first, and pays its normal benefit. The Secondary Plan computes its benefit second, and may reduce its benefit payment so that the insured does not receive more than 100% reimbursement of expenses. In no event would the DCC/CSA Welfare Fund's liability exceed the benefits payable in the absence of COB.

The order of payment is determined as follows:

1. If one plan does not have a COB provision, it will be Primary;
2. If the patient is our (DCC/CSA Welfare Fund) member, the DCC/CSA Welfare Fund is the Primary Plan. However, if the patient is the spouse of our member, and is covered under another group plan, the other plan is Primary and the DCC/CSA Welfare Fund is Secondary;
3. If the patient is a dependent child under both parents' plans, then the plan of the parent whose birthday occurs first within the calendar year will be Primary, except that where the parents are separated or divorced, the following rules will apply:

   (a) If a court order establishes that one of

the parents is financially responsible for medical, dental or other health care expenses of a child, the contract under which the child is a dependent of that parent shall be Primary;

(b) If financial responsibility has not been established by a court order and the parent with custody has remarried and the child is also covered as a dependent of the step-parent, then the order of payment shall be:

1st: The contract under which the child is a dependent of the parent with custody.

2nd: The contract under which the child is a dependent of the stepparent.

3rd: The contract under which the child is covered as a dependent of the parent without custody.

4th: If none of the above applies, then the plan under which the child has been enrolled the longest will be Primary.

However, the plan covering the member as a laid-off or retired employee, or as a dependent of such a person, shall be Secondary and the plan covering the member as an active employee shall be Primary, as long as the other plan has a COB provision similar to this one.

If you and your spouse are both members of the DCC/CSA Welfare Fund, you can either be covered as an employee, or as a dependent, but not as both. The Fund will pay benefits only once and will not coordinate with itself.

NOTE

Whenever the DCC/CSA Welfare Fund has made payments which are in excess of the maximum amount of payment necessary to satisfy a claim under the Coordination of Benefits provision, the Fund shall have the right to recover such excess payments which were made to a member or eligible dependent.

BASIC BENEFITS

The Council Of School Supervisors And Administrators Local 1 AFSA through its negotiated agreement with Day Care Council and The Administration for Child Services / Agency For Child Development has arranged that each member covered under this agreement be provided with basic hospital/medical coverage. Members are given a choice of coverage either in HIP/HMO or Blue Cross/GHI. Members may enroll in either plan, and may change their choice of coverage during the yearly enrollment period.

These basic benefits are funded through the general budget of each Day Care Center. The Human Resources Administration (HRA), administers the HIP/HMO and GHI programs and Local 205, D.C. 1707 Welfare Fund administers the Blue Cross program for covered Day Care employees.

It is the responsibility of each employee to make certain that the coverage available to the employee is activated by appropriate application and notice filed with the HRA, for HIP/HMO and GHI coverage and Local 205, D.C. 1707 Welfare Fund located at 75 Varick Street, New York, N.Y. 10013, for Blue Cross coverage.

In addition to these basic benefits, the collective bargaining agreement also provides funding for supplemental benefits to be provided by the DCC/CSA Welfare Fund. Funding for these supplemental Welfare Fund benefits is also provided in the general budget of each Day Care Center. The center is required to forward to the Fund, on a monthly basis, the appropriate allocated payment to provide covered members with their supplemental benefits.

MEMBERS ENROLLED IN HIP/HMO

BASIC COVERAGE

Hospital and medical coverage is provided for members, their legally married spouse, and dependent children who have not reached their 19th birthday, or dependent children who are full time students and have not reached their 23rd birthday.

HIP/HMO, a Health Maintenance Organization, provides both medical and hospital services to its members. Medical care is provided through medical groups affiliated with HIP in more than 50 medical centers located throughout the five boroughs, Long Island, and Westchester County.

At the HIP centers, members choose their personal family physicians for adults and pediatricians for children to take care of their primary needs. The family physicians have the responsibility for referrals to other specialists affiliated with the medical group and for referrals for X-ray and laboratory services.

Members of HIP/HMO, by using the HIP/HMO system, have no doctor bills for covered medical treatment, no hospital bills when they are admitted to a hospital by a HIP/HMO physician, and no claim forms, except for certain emergency medical care or anesthesia. Emergency hospitalization and medical care are covered when a member is traveling on vacation, or when so severely injured that waiting for authorization by the medical group is not advisable. Members are advised to obtain a full description of the HIP/HMO program from their Day Care Centers, HRA or HIP so as to be advised as to the full benefits provided by this program as well as the limitations and exclusions.

SUPPLEMENTAL COVERAGE PROVIDED BY YOUR DCC/CSA WELFARE FUND

(Active Members And Their Dependents Only)

Your DCC/CSA Welfare Fund provides supplementary coverage for the following services that are not now covered by the employer provided basic HIP/HMO benefit program:

- Private duty nursing expenses, whether in or out of hospital, when provided by a registered nurse or a licensed practical nurse, on the medical recommendation of your physician and deemed by the Fund to be necessary care;
- Anesthesia and its administration;
- Necessary emergency professional ambulance services to and from the nearest hospital where care and treatment can be given:
- Oxygen and its administration;
- Necessary appliances or prostheses not of general nature, prescribed by a physician specifically for the patient in the treatment of a specific ailment (expenses incurred for general appliances such as heating pads, back-supportive car seats and other similar appliances for general use are not considered covered expenses);
- Orthotics prescribed by a physician and custom molded to the patient's foot are covered. The maximum benefit is $ 400.00 per orthotic with an annual limit of 2 orthotics per patient.
- Wigs required for members suffering from alopecia areata or loss of hair due to cancer therapies are covered up to $700 annually;
- Reasonable and customary charges for in or out of hospital medical or surgical care provided "out of area" for which the member is not fully reimbursed by HIP/HMO;
- Necessary physical therapy or speech therapy up to a maximum of 30 treatments per calendar year;
- Routine podiatry care, to a maximum of four

treatments during a calendar year, if not provided by HIP/HMO. Major foot care such as hammer toe and other surgery is not considered routine podiatry care and is not covered by the Fund. Such treatment is covered by HIP/HMO;

- The $25 co-payment charge for out-of-hospital psychiatric treatment provided by HIP/HMO. **The Fund will not reimburse expenses incurred for charges made by a hospital for inpatient care.**

The DCC/CSA Welfare Fund will reimburse reasonable and customary expenses incurred for the above listed services at 80% after a $150 calendar year deductible (a maximum of $450 for the family). The Fund will provide reimbursement of 80% up to a maximum payment of $10,000 per family during any calendar year. Expenses incurred which may be deemed to be HIP/HMO covered expenses must first be submitted to HIP/HMO for any primary payment which may be due from HIP/HMO.

MEMBERS ENROLLED IN BLUE CROSS/GHI

EFFECTIVE JULY 1, 2004, THE DCC/CSA WELFARE FUND WILL NOT PROVIDE SUPPLEMENTAL BENEFITS FOR MEMBERS ENROLLED IN THE GHI/BLUE CROSS HEALTH PLAN. ONLY THOSE SERVICES SPECIFICALLY ITEMIZED IN THIS BOOKLET ARE CONSIDERED COVERED SERVICES FOR THESE MEMBERS.

BASIC COVERAGE

The basic coverage funded by HRA and administered by Local 205 provides hospital coverage through Blue Cross consisting of 21 days of semi-private accommodations at full coverage and 180

days at 50% in a Blue Cross affiliated hospital. Emergency room coverage is also included in the coverage. Dependent children are covered up to their 19th birthday. There is no extended coverage for full-time students. Medical expenses are reimbursed through a GHI provided indemnity plan that makes payments for physician's bills based on a schedule of allowances. This schedule is minimal and has not been improved for many years. There is no deductible or coinsurance required. This portion of the coverage is administered by HRA.

Utilization Management

Empire Blue Cross Blue Shield has implemented a Utilization Management program to help you make informed choices about your health care while helping reduce costs.

You must notify Empire BlueCross Blue Shield whenever a doctor recommends hospitalization for you or your covered dependent. It is very important that you follow this rule carefully. If you fail to notify Empire Blue Cross Blue Shield you will have to pay a penalty of $ 100.00 a day for the first five (5) days of hospitalization. If you have any questions, you may contact Empire Blue Cross Blue Shield at 1-800-841-2530.

SUPPLEMENTAL COVERAGE PROVIDED BY YOUR DCC/CSA WELFARE FUND

(Active Members And Their Dependents Only)

The following services, not provided or not fully reimbursed by the basic GHI coverage, will be reimbursed by the DCC/CSA Welfare Fund after a $150 annual deductible ($450 per family) at 80% of reasonable and customary charges up to a maximum of $10,000 per family per calendar year. Dependents who are full-time students, and

have not reached their 23rd birthday, are covered for these services:

- Private duty nursing expenses, whether in or out of hospital, when provided by a registered nurse or a licensed practical nurse, on the medical recommendation of your physician and deemed by the Fund to be necessary care;
- Necessary appliances or prostheses, approved by the Fund, not of a general nature, prescribed by a physician specifically for the patient in the treatment of a specific ailment (expenses incurred for general appliances such as heating pads, back-supportive car seats and other similar appliances for general use are not considered covered expenses);
- Necessary chiropractic, physical therapy or speech therapy up to a maximum of 30 treatments per calendar year;
- Wigs required for members suffering from alopecia areata or loss of hair due to cancer therapies are covered up to $700 annually.
- Necessary emergency professional ambulance services to and from the nearest hospital where care and treatment can be given:
- Orthotics prescribed by a physician and custom molded to the patient's foot are covered. The maximum benefit is $ 400.00 per orthotic with an annual limit of 2 orthotics per patient.

All claims must be submitted to the primary carrier first (Blue Cross or GHI). Copies of the claim and corresponding payment from the primary carrier may then be submitted to the DCC/CSA Welfare Fund for supplemental coverage as described above.

NOTE: The basic and supplemental benefits described above for members enrolled in HIP/HMO or Blue Cross/GHI are applicable only to actively-employed members and their eligible dependents. Benefits provided to eligible retirees are described separately.

COVERAGE FOR DEPENDENT FULL TIME STUDENTS AGE 19 TO 23

Unmarried dependent children between the ages of 19 and 23 are covered for benefits provided they are full-time students. Evidence of full-time student status must be supplied to the Fund each semester, by using the Fund's Student Verification Form or providing a Bursar's Receipt which defines the student's status. Such evidence will be retained by the Fund,

FILING OF CLAIMS

All claims for coverage provided by Blue Cross are filed directly with Blue Cross.

All claims for coverage provided by GHI are filed directly with GHI. Claims must be filed with GHI within 90 days after the end of the calendar year in which services are rendered.

All claims for coverage provided by the Day Care Council/CSA Welfare Fund are filed directly with the Fund. Members should contact the Fund to request the appropriate claim forms. The Fund will not be liable for reimbursement of expenses rejected by GHI because of late or improper filing or for services not covered by GHI, except for those services specifically listed as covered expenses by the Fund.

Claims for all benefits provided by the Fund must be filed with the Fund no later than 12 months from the date services were rendered. Where the Coordination of Benefits provision is applicable, and the DCC/CSA Welfare Fund is the secondary plan, claims must be submitted within 12 months from the date payment was

made under the primary plan. Claims that are not filed in accordance with the above time limitations will not be accepted.

DENTAL BENEFITS

The Day Care Council/CSA Welfare Fund offers to each member and his or her eligible dependents a choice of one of three different dental plans. There is a separate brochure (available upon request) for each of the plans that should be read carefully. In order for you to understand the difference between the plans and your options, so that you can make an intelligent selection of the dental plan that best meets your needs, the following is a summary of these four plans.

THE SIDS DENTAL PROGRAM

Option 1: An Indemnity Plan Administered by Self Insured Dental Services

- You can use any dentist of your own choosing any where in the world,
- You are reimbursed on the basis of a Schedule of Allowances that is described in a separate brochure. Your reimbursement is, of course, subject to the limitations in the schedule of maximum allowances.
- You are also provided with a listing of dentists who have consented to be participating providers. As participating providers, they have agreed to accept the reimbursement listed in the "Schedule of Allowances" as payment in full, subject to any co-payments or maximum allowances listed in the "Schedule".

HEALTHPLEX DENTAL PLAN FOR NEW YORK – NEW JERSEY

Option II: Enrollment in a pre-paid dental plan, Dentcare Dental plan by Health-Plex, for members residing either full or part time, in the New York City - New Jersey Metropolitan area.

- This plan is a pre-paid dental plan similar in concept to an HMO. Your Fund pays for the cost of this plan,
- A member who selects this plan, upon enrollment in the plan, must select a primary care dentist from an extensive listing of participating Dentcare dentists. You may not use any other dentist unless referred by your Dentcare dentist.
- This participating Dentcare dentist will provide a member and the member's eligible dependents with total dental care at no charge to the patient other than a small charge for two or three services listed in the descriptive materials relating to crowns and orthodontics.
- Under this plan, there are no claim forms to be filed since the services are provided without a fee. The dentist is paid by the Fund each month, whether or not he has treated the patient. In effect, he, the dentist, is on a retainer for the services.
- Specialized dental care, such as endodontics, oral surgery, and periodontics, if needed, is provided by specialists to whom your primary care dentist refers you.
- This plan has no dollar maximums and there are few restrictions in terms of limitations and service
- Should you require emergency dental care while out of your geographic covered area, the cost for such care may be submitted to Healthplex for possible reimbursement.

HEALTHPLEX – FLORIDA [RETIREES ONLY]

Option III: **A pre-paid dental plan, American Dental Plan of Florida, sponsored by Healthplex for retired members who reside in Florida**

- This plan is similar in structure and design to the plan described in Option II, the Healthplex, (Dentcare), pre-paid dental plan for members residing in New York and New Jersey, However, since the American Dental Plan is a licensed Florida Dental Plan, it must conform to Florida Insurance Laws and some restrictions (described below) apply.
- A member who selects this plan, upon enrollment in the plan, must select a primary care dentist from an extensive listing of participating American Dental Plan dentists. You may not use any other dentist unless referred by your American Dental Plan dentist.
- Under this plan, because of Florida regulations, the dentist must charge a fee for some of the services listed while other services are provided without charge.
- Healthplex will reimburse the patient, for all or a portion of the charges made by the dentist, as listed in the "Schedule of Benefits and Co-Payments Florida" which is provided each member.

SUMMARY

You may enroll in any one of the three plans listed above.

If you do not submit an application for enrollment in either of the Healthplex plans, (Dentcare for retirees living in New York, New Jersey or the American Dental plan for members living in Florida), you will automatically be covered by the SIDS plan.

You will have an opportunity to change your dental plan during the enrollment period each October for the next calendar year, Members will not be locked into any dental plan for more than the year in which they are enrolled. Members who make no changes each October will remain in the plan previously selected.

OPTICAL BENEFITS

All members and their eligible dependents are covered for optical benefits.

Members have a choice of utilizing the services of participating optical centers through which a full service of benefits is provided without cost, or using non-participating optical centers and receiving reimbursement based upon a schedule of allowances. This benefit is provided once in a 12 month period for members and eligible dependents.

Participating Centers

Members and eligible dependents utilizing participating optical centers are provided with the following paid in full services: eye examination, including glaucoma testing for adults*; single vision, bifocal, blended bifocal or trifocal glass or plastic lenses; standard hard or soft daily wear contact lenses and a wide choice of frames, including a selection of designer frames.

Members who desire frames not included in the free choice selection may be subject to an additional surcharge by the optical center since these services may exceed the Fund's allowance for covered frames or lenses.

Direct Reimbursement

If you use an optical center or optician, which is not a participating center or optician, you must pay the center or optician directly, in which case you will be reimbursed by the Fund for the allowance to which you are entitled as follows:

Schedule of Maximum Allowances

Single vision lens and frame,
with or without examination . . . . $ 65.00
Bifocal lenses and frame,
with or without examination . . . . $ 65.00
Single Vision Lenses only . . . . $ 35.00
Bifocal lenses only . . . . $ 35.00
Frame only . . . . $ 25.00
Contact lenses, including all services . . . . $ 65.00

***The Fund does not cover the cost of eye examinations. This service is provided free of charge by participating optical centers only in New York .**

How to Obtain Benefits

Write or call the Fund office requesting an optical certificate. You must specify for whom the certificate is intended. Certificates are not transferable and must be returned to the Fund if not used. Provide your Social Security number when submitting your request.

A listing of Participating Optical Centers will be provided to you with your Optical Certificate. The certificate is to be signed and given to the participating center when used. Should you not use a participating provider, certificates must be completely filled out and returned to the Fund with a paid receipt attached showing proof of purchase in order for the Fund to provide the appropriate reimbursement.

HEARING AID BENEFIT

The Fund provides reimbursement of up to $600 for the cost of a hearing aid instrument. This benefit is provided once every three years for all eligible active and retired members and their eligible dependents.

Members may request a Hearing Aid Voucher which can be used at any licensed hearing aid provider of their choice.

There are a number of hearing aid providers who have agreed to provide the necessary examination and instrument to our members at a co-pay charge of only $35. The Fund will pay the participating provider up to $600 for the instrument. The names and addresses of the participating providers will be sent along with requested vouchers.

PRESCRIPTION DRUG BENEFITS

Active Members

All active members and eligible dependents are covered for prescription drugs through the DCC/CSA Welfare Fund Prescription Drug Plan administered by Express Scripts, Inc.

This benefit provides three ways for you to obtain prescription drugs:

Obtaining Drugs Through Your Participating Neighborhood Pharmacy

You will be issued a drug card, which can be used at any participating pharmacy nationwide.

Express Scripts is a nationally recognized drug plan. You will find pharmacies across this country who will be eager to accept this plan. The Fund can be contacted for referral to a participating Express Scripts pharmacy in your geographic area.

Your doctor's own prescription form will be all that is required along with your card.

There is a $ 50.00 per person, $ 150.00 per family deductible at the local pharmacy. This means that the first $ 50.00 is paid by the member. After the deductible has been met, the member will pay a 20% co-payment for medications purchased at the local pharmacy. You are allowed an original fill of a prescription and one refill at the local pharmacy: all subsequent refills must be made through the mail-order program. Exceptions to this mandatory mail policy are antibiotics and other medications which must be constantly monitored and dosages adjusted by a physician.

Pharmacies equipped with the appropriate electronic devices will be able to input and receive immediate approval for your claims. Pharmacies

that have this equipment will receive immediate notice and approval for the claim and payment will be expedited electronically. Adjustments of eligibility, limitations in coverage, etc., will all be transmitted to the pharmacy electronically and instantly. New cards will be issued approximately every two years, or as needed, due to changes in eligibility, changes in dependents, or loss or breakage. Cards reissued to a member due to loss or breakage may require a $5 fee for replacement,

Chronic or Maintenance Drug Plan

You must utilize our mail order drug plan to provide long-term maintenance drugs for members with chronic medical conditions.

You must utilize a special pre-addressed mail order envelope. Your doctor can prescribe up to a 60-day supply of medication. The doctor's prescription, along with a check for $ 25.00 for a brand-name medication or $ 10.00 for a generic medication, representing your co-payment, should be sent in the envelope. A supply of envelopes may be obtained by contacting the Fund office.

A toll free number is available for you to use to get immediate answers to your questions regarding your prescription.

You are advised to encourage your doctor to allow for the substitution of the generic equivalent for the drugs he prescribes since you are paying a higher amount for brand-name drugs. The pharmacists at Express Scripts, with your permission, will be happy to call your doctor and suggest a generic substitute if the doctor has not authorized automatic substitution on the prescription form. If the doctor writes DAW (Dispense As Written) in the box on the prescription form, Express Scripts must, under the law, dispense the drug as prescribed without making a generic substitution. If the doctor does not put DAW in the box, the

pharmacist will be able to substitute a generic equivalent automatically and save you money.

Direct Reimbursement

Should you, for any reason, have to pay for your drugs because you did not have your drug card or you used a non-participating pharmacy, you may submit your itemized bill to the Fund, utilizing a special direct reimbursement form. The claim will be processed and you will receive the same reimbursement that the pharmacist would have received had the claim been processed through the regular procedure. Limits on amounts dispensed and refills are the same as described above for drugs obtained from participating neighborhood pharmacies.

Limitations

Please be advised of the following limitations of the prescription drug program.

The drug plan covers only prescription drugs required to preserve life. Prescription drugs prescribed for cosmetic purposes are not covered, Drugs such as wrinkle removers, hair restorers or drugs used to change smoking habits are also not covered.

Needles, syringes or other companion implements, as well as appliances or medical supplies, are not covered by the drug plan. Expenses incurred for such materials must be submitted to your basic City-provided health plan such as GHI, or to the Fund if rejected by your basic plan, for possible coverage by the Fund as a covered major medical expense.

Prescription drugs (oral or injectable) required to treat diabetes are covered by the basic health plan (GHI or HIP/HMO) in which you are enrolled, not the Fund. Also covered by the basic plan are syringes, needles, test strips and blood sugar meas-

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uring devices. Contact your health insurance carrier to obtain these drugs and materials. The Fund will consider your co-payment costs, if any, charged by your health insurance carrier for drugs required for the treatment of diabetes as a covered expense under the Fund's supplemental medical benefits program,

Medications for which there are over-the-counter equivalents are not covered, except in extenuating circumstances with a physician's letter of medical necessity.

Should the eligibility of a member or a dependent terminate after issuance of a card, or should a card be issued for an ineligible member or dependent in error, the member shall be responsible for making restitution to the fund for any claims paid for such ineligible members or dependents.

Prescription drugs are covered up to a maximum of $10,000 per patient per calendar year.

LIFE INSURANCE BENEFITS

(Actively-employed Members only, Not Applicable to Dependents or Retirees)

A $10,000 Life Insurance benefit insured by Guardian Life Insurance will be paid to a beneficiary of your choosing in the event of your death. Members are advised that they may designate one or more beneficiaries at the time of their enrollment as members. Changes in beneficiary may be made, at the discretion of the member, by the completion of a new beneficiary card.

RETIREE BENEFITS

Eligible retirees who apply to the fund for continued coverage within 12 months of the date of their retirement and make timely payments of the appropriate contribution will be covered for the following benefits.

Supplemental Medical Coverage:*

The benefit coverage for retirees is the same as the coverage provided by the Fund to active members in terms of deductibles maximums and co-payments. Coverage to retirees however, is limited to *only* necessary prescribed private duty nursing services.

Outpatient hospital, laboratory or x-ray services, or services provided in a doctor's office are *not* covered.

Emergency professional ambulance services to the nearest appropriate hospital, oxygen services provided at home and necessary prescribed appliances or prosthesis, approved by the Fund, as well as wigs for patients suffering from alopecia areata or loss of hair due to cancer therapies are covered by the Fund. Reimbursement for the cost of these services are also subject to the same limits and provisions previously described for actively employed members.

* The above supplemental medical coverage will be provided only if the member has a basic health plan in place such as HIP/HMO, Blue Cross/Blue Shield or Blue Cross/Medicare. The fund will assist retirees in obtaining such coverage with the desired insurance carriers if requested.

Prescription Drug Coverage

All participating retired members and eligible dependents are covered for prescription drugs through the DCC/CSA Welfare Fund Prescription Drug Plan administered by Express Scripts, Inc..

This benefit provides three ways for you to obtain prescription drugs:

Obtaining Drugs Through Your Participating Neighborhood Pharmacy

You will be issued a drug card, which can be used at any participating pharmacy nationwide.

Express Scripts is a nationally recognized drug plan. You will find pharmacies across this country who will be eager to accept this plan. The Fund can be contacted for referral to a participating Express Scripts pharmacy in your geographic area.

Your doctor's own prescription form will be all that is required along with your card.

There is a $ 50.00 per person, $ 150.00 per family deductible at the local pharmacy. This means that the first $ 50.00 is paid for by the member. After the deductible has been met, the member will pay a 20% co-payment for medications purchased at the local pharmacy. You are allowed an original fill of a prescription and one refill at the local pharmacy: all subsequent refills must be made through the mail-order program. Exceptions to this mandatory mail policy are antibiotics and other medications which must be constantly monitored and dosages adjusted by a physician.

Pharmacies equipped with the appropriate electronic devices will be able to input and receive immediate approval for your claims. Pharmacies that have this equipment will receive immediate notice and approval for the claim and payment will be expedited electronically. Adjustments of eligibility, limitations in coverage, etc., will all be

transmitted to the pharmacy electronically and instantly. New cards will be issued approximately every two years, or as needed, due to changes in eligibility, changes in dependents, or loss or breakage. Cards reissued to a member due to loss or breakage will require a $5 fee for replacement.

Chronic or Maintenance Drug Plan

You must utilize our mail order drug plan to provide long-term maintenance drugs for members with chronic medical conditions.

You must utilize a special pre-addressed mail order envelope. There is a $50.00 per person, $150.00 per family deductible for the mail order program. Your doctor can prescribe up to a 60-day supply of medication. The doctor's prescription, along with a check for $25.00 for a brand-name medication or $10.00 for a generic medication, representing your co-payment, should be sent in the envelope. A supply of envelopes may be obtained by contacting the Fund office.

A toll free number is available for you to use to get immediate answers to your questions regarding your prescription.

You are advised to encourage your doctor to allow for the substitution of the generic equivalent for the drugs he prescribes since you are paying a higher amount for brand-name drugs. The pharmacists at Express Scripts, with your permission, will be happy to call your doctor and suggest a generic substitute if the doctor has not authorized automatic substitution on the prescription form. If the doctor writes DAW (Dispense As Written) in the box on the prescription form, Express Scripts must, under the law, dispense the drug as prescribed without making a generic substitution. If the doctor does not put DAW in the box, the pharmacist will be able to substitute a generic equivalent automatically and save you money.

Direct Reimbursement

Should you, for any reason, have to pay for your drugs because you did not have your drug card or you used a non-participating pharmacy, you may submit your itemized bill to the Fund, utilizing a special direct reimbursement form. The claim will be processed and you will receive the same reimbursement that the pharmacist would have received had the claim been processed through the regular procedure. Limits on amounts dispensed and refills are the same as described above for drugs obtained from participating neighborhood pharmacies.

Limitations

Please be advised of the following limitations of the prescription drug program.

- The drug plan covers only prescription drugs required to preserve life. Prescription drugs prescribed for cosmetic purposes are not covered, Drugs such as wrinkle removers, hair restorers or drugs used to change smoking habits are also not covered.
- Needles, syringes or other companion implements, as well as appliances or medical supplies, are not covered by the drug plan. Expenses incurred for such materials must be submitted to your basic City-provided health plan such as GHI, or to the Fund if rejected by your basic plan, for possible coverage by the Fund as a covered major medical expense.
- Prescription drugs (oral or injectable) required to treat diabetes are covered by the basic health plan (GHI or HIP/HMO) in which you are enrolled, not the Fund. Also covered by the basic plan are syringes, needles, test strips and blood sugar measuring devices. Contact your health insurance carrier to obtain these drugs and materials. The Fund will consider your co-payment costs, if any, charged by your health insurance carrier for drugs required for the

treatment of diabetes as a covered expense under the Fund's supplemental medical benefits program,

- Medications for which there are over-the-counter equivalents are not covered, except in extenuating circumstances with a physician's letter of medical necessity.

Should the eligibility of a member or a dependent terminate after issuance of a card, or should a card be issued for an ineligible member or dependent in error, the member shall be responsible for making restitution to the fund for any claims paid for such ineligible members or dependents.

PLEASE NOTE: There is an annual maximum of $1,500.00 per person, for local pharmacy and mail-order pharmacy combined, for the prescription drug benefit for retired members.

Other Benefits

Retired members will be provided the same coverage as the coverage provided actively employed members for dental, optical and hearing aid benefits. See those pages for a full description of these benefits.

YOUR RIGHT TO CONTINUATION OF COVERAGE

The Federal Government enacted the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) which allows members and their eligible dependent the option of continuing their coverage for certain benefit provided by their Welfare Fund should their coverage be terminated. Under this law the Fund will make available to the members, and/or eligible dependents, an opportunity to purchase most of the benefits at the group cost to the Fund plus an administration charge not to exceed 2% of such cost.

You and your eligible dependents are permitted to purchase the coverage provided by the Fund for up to 18 months when termination of your coverage is due to termination of your employment for reasons other than gross misconduct. If disabled, (as determined under the Social Security Act), COBRA coverage is provided for 29 months. rather than 18 months.

Your dependents are permitted to purchase their coverage for a period of up to 36 months on the following conditions:

- Spouse and children upon the death of the covered member.
- The spouse upon divorce or legal separation from the member
- The spouse and children of medicare eligible members should the member cease to participate in the Fund's benefit program.
- Dependent children when they cease to be dependent children as defined in the Plan.

Coverage by the Fund cannot be continued beyond any of the following dates:

- The date on which the Fund terminates its benefit program.

- The date the premium is not paid by the individual.
- When the individual becomes covered under any other health plan.. if that plan does not include any pre-existing limitations of exclusions, or is eligible for Medicare benefits,
- In the case of a spouse, when the spouse remarries and becomes covered under another group health plan.

Members are advised that, if they wish to have continued coverage for themselves and/or any of their eligible dependents, they must notify the Fund immediately should any of the following circumstances occur:

- The member's job is terminated and no further contributions for coverage will be provided to the Fund by the employer
- The member and spouse, become legally separated or divorced.
- A dependent child is over 19 years of age and not a full time student or has reached his/her 23rd birthday

Upon receiving notification, the Fund will send an application for continued coverage to the member and/or the eligible dependent. The application will indicate the benefits to be provided, the cost for the coverage and the manner in which payments are to be made to the Fund.

Your opportunity to continue to obtain benefits from the Fund under this optional paid program will be available to you for no more than 60 days from the time you receive the application for coverage. if the application is not filed within that period of time, the Fund may not be able to offer such optional paid coverage.

Continuation of coverage under COBRA for your employer-provided basic CORE benefits for hospitalization, through Blue Cross, must be applied for through Local 205, and coverage for GHI or HIP/HMO must be applied for through HRA.

YOUR RIGHTS UNDER ERISA

As a Participant in the DCC /CSA Welfare Fund 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:

- 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 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 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 updates Summary Plan Description. The Administrator 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 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.
- 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, 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 to Plan participants, ERISA imposes duties upon 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 fund benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare fund 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 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 which is denied or ignored, in whole or in part, you 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 domestic relations order or 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 the 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 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 office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory of 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.

STATEMENT OF PRIVACY PRACTICES IN COMPLIANCE WITH HIPAA PRIVACY REGULATIONS

THIS STATEMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Effective Date of Notice: April 14, 2003

The DCC/CSA Welfare Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan 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 Plan's privacy practices.

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

SECTION I - NOTICE OF PHI USES AND DISCLOSURES

Required PHI Uses and Disclosures

Upon your request, the Plan 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 Plan's compliance with the privacy regulations.

The Plan 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.

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 Plan 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 preauthorizations).

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

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 manage-

ment and general administrative activities.

For example, the Plan 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 Plan 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 Plan is not required to agree to your request.

The Plan 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 offices:

DCC/CSA Welfare Fund
Douglas V. Hathaway, Ph.D., Privacy Officer
16 Court Street, 34th Floor
Brooklyn New York 11241
(718) 6524-2600

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 Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, 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 decisions 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 Plan 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 the following officer: [insert name or title of person or office responsible for managing requests, telephone number and address].

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 Plan 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 Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan 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 in a designated record set should be made to the following officer: [insert name or title of person or office responsible for managing requests].

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 Plan will also provide you with an accounting of disclosures by the Plan 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 Plan 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 Plan 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 PLAN'S DUTIES

The Plan 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 Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all present participants and beneficiaries via mailing and notification in the CSA Newsletter.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or 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 Plan 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 Plan'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 Plan 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 PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer:

DCC/CSA Welfare Fund
Douglas V. Hathaway, Ph.D., Privacy Officer
16 Court Street, 34th Floor
Brooklyn New York 11241
(718) 6524-2600
dhathaway@csawf.org

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 S.W., Washington, DC 20201.

The Plan 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 the following officer

DCC/CSA Welfare Fund
Douglas V. Hathaway, Ph.D., Privacy Officer
16 Court Street, 34th Floor
Brooklyn New York 11241
(718) 6524-2600
dhathaway@csawf.org

CONCLUSION

PHI use and disclosure by the Plan 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.

ADDITIONAL INFORMATION

FUND ADMINISTRATION

The Day Care Council/CSA Welfare Fund administrated by a joint Board-of-Trustees which acts as Plan Administrator. The address of the Board is:

Board of Trustees of Day Care Council/
CSA Welfare Fund
16 Court Street 34th Floor
Brooklyn, New York 11241

Current members of the Board of Trustees are listed on page 1 and they can be communicated with by contacting them at the address indicated on that page. The Board of Trustees governs the Welfare Fund in accordance with an Agreement and Declaration of Trust, The Board of Trustees employs an Administrator who is responsible for the day-to-day operation of the Fund. Trustees are appointed by their respective organizations to serve on the Board without compensation for their services.

The Board of Trustees' Employer Identification Number Is 11-2504726. The Plan number is 501. The fiscal yearend date is June 30th.

The Board of Trustees has designated Fund Counsel Meyer, Suozzi, English and Klein of 1505 Kellum Place, Mineola, New York 11501 as the agent for the service of legal process. Legal process may also be served upon any Trustee or the Fund Administrator. The Fund's assets and reserves are held in custody and invested by the Board of Trustees.

EMPLOYER CONTRIBUTIONS

All contributions to the Plan are made by employers in accordance with the current collective bargaining agreement with the Council of School Supervisors and Administrators of the City of New York, Local 1, AFSA AFL-CIO and Day Care Council of New York, Inc. Benefits are provided from the Fund's assets which are accumulated: under the provisions of the Collective Bargaining Agreement and Trust Agreement and held in a Trust Fund for the purpose of providing benefits to eligible members and dependents as well as defraying reasonable administrative expenses.

INSURANCE PROVISIONS

Some of the benefits are provided through insurance policies. The complete terms of the insured benefits are set forth in the group insurance policies or contracts with the following organizations:

Guardian Life Insurance Company
Empire Blue Cross and Blue Shield

The procedures to follow for filing a claim for benefits as well as the benefit descriptions are set forth in this Health Benefits booklet. The Plan's requirements with respect to eligibility, as well as circumstances that may result in disqualification, ineligibility, denial or loss of any benefits are also fully described in this booklet.

APPEAL PROCEDURES

A claimant who has received a notice that his or her claim has been denied may request a review of the denied claim within 60 days the receipt of the notice of denial. Request for review must be made in writing and should be sent to the Welfare Fund Office. A claimant who has not received a decision on a claim for benefits within 90 days (or 180 days in special circumstances) may also request a review of the claim. A claimant or his/her authorized representative may request a review, may have the opportunity to review pertinent documents, and may submit issues and comments in writing.

DECISIONS ON REVIEW

Decisions on the Review will be made by the insuring organization on any question involving the terms of an insurance contract. The Board of Trustees will review any other question on the benefit program. In addition the Board will render a decision within 60 days after the receipt of the request for a review unless special circumstances require an extension of time for processing, in which case a decision shall be rendered within 120 days. The decision of the Board of Trustees will be in writing and will include the specific reason(s) for the decision.

Nothing in the foregoing statement is meant to interpret or extend or change in any way the provisions expressed in the Plan or insurance policies. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan whenever, in their judgement conditions so warrant.

FUTURE OF THE PLAN AND PLAN TERMINATION

This booklet includes information concerning the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide. We refer you to the terms of the official documents which detail the eligibility rules, qualification rules, benefits, limitations and exclusions from coverage.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the plan is reserved by the Board of Trustees, in accordance with the declaration of Trust. In addition, the continuance of the plan is subject to the maintenance of collective bargaining agreements which provide for employer contribution to the Trust Fund.

If it ever becomes necessary to terminate the plan at some future date, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of the plan participant and to defray the cost of reasonable administration and termination expenses. In no event will any of the assets revert to any employer or to the union. In the event of termination of the plan, the Trust Funds are to be used exclusively to continue the payment of benefits provided for in the plan to eligible employees, their dependents, beneficiaries, or their estates, to defray reasonable administration and termination expenses and to otherwise effectuate the purpose of the Trust Fund. Upon the necessity for termination, the Trustees will establish a plan to be applied to the balance of assets in the Trust Fund so that the assets would be applied solely for these purposes.

Upon final liquidation of the plan, participants and beneficiaries would have no further rights or interest in the Welfare Fund.

MODIFICATION OF BENEFITS AND ELIGIBILITY RULES FOR RETIREES AND THEIR DEPENDENTS

This booklet includes information concerning the benefits provided by the Trustees to retired employees and their dependents and the circumstance which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits that a retired participant or beneficiary might otherwise reasonably expect the plan to provide.

The benefits and eligibility rules applicable to retired employees and beneficiaries have been established by the Trustees as part of an overall benefit program for beneficiaries. The right to amend or modify the eligibility rules and plan of benefits for retirees, employees and beneficiaries is reserved by the Board of Trustees, in accordance with the Declaration of Trust. The continuance of benefits for retirees and their dependents and the eligibility rules relating to a qualification therefore are subject to modification and revision by the Board of Trustees in accordance with their responsibilities and authority contained in the Declaration of Trust.

In accordance with the rules and regulations and the Trust Agreements, no employee has a vested interest in the benefits provided for retired employees and their dependents. In the event of termination of the Welfare Plan as stated above, the Trustees reserve the right to terminate the program of benefits for retired employees and

there shall be not be any vested right by any retired employee or dependent or beneficiary nor contractual rights after the disposition of all plan assets and the termination of the plan. Retired employees and their dependents shall not have any priority with respect to the disposition of plan assets in connection with the termination of this Welfare Plan.

PLAN INTERPRETATIONS AND DETERMINATIONS

This booklet describes the main features of our Plan.

The Board of Trustees is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out their responsibility, the Board of Trustees, or their designee, shall have exclusive authority and discretion to: determine whether an individual is eligible for benefits under the Plan; determine the amount of benefits, if any, and individual is entitles to from the Plan; interpret all of the the provisions of the plan; and interpret all of the terms used in the Plan.

All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under the Plan; be given deference in all courts of law; and not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith.

CAUTION

This booklet and written material from the Trustees and the Funds Office personnel are your only authorized sources for Plan information.