District Council 37
Health & Benefit Fund

420 West 45th Street, 3rd Floor
New York, NY 10036
Telephone: (212) 334-0096
Fax: (212) 274-0104

February 25, 2025

Dear Member,

This year's Open Enrollment period will begin on March 1 through 21, 2025, and benefit elections will become effective on April 1, 2025.

Only during the Funds Open Enrollment period are you permitted to re-enroll or make changes to your medical coverage; unless there is a special enrollment event. Otherwise, you will have to wait until next year's Open Enrollment period.

To ensure you continue receiving all communications from the Fund office, please notify the Fund of any changes to your contact information such as mailing address, phone number, and email address.

Sincerely,

Randy S. Paul
Fund Administrator

Important Notice: Grandfathered Health Plan

Plan Years beginning April 1, 2011, the Fund has conformed with the Patient Protection and Affordable Care Act. The District Council 37 Health & Benefit Fund believes that this health care plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other health plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain consumer protections in the Affordable Care Act, such as the elimination of lifetime and annual limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Randy S Paul, Fund Manager, at 212-334-0096. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

District Council 37
Health & Benefit Fund

420 West 45th Street, 3rd Floor
New York, NY 10036
Telephone: (212) 334-0096
Fax: (212) 274-0104

Dear Plan Participant,

Each year you have the opportunity to review your current health insurance benefits and make changes to these benefits for the upcoming benefit period. This year's open enrollment period will begin on March 1 through March 21, 2025, with your elections taking effects on April 1, 2025.

If you are currently enrolled in the Plan and **do not want to make any changes to your current coverage**, **no action is necessary**. Your coverage will continue through the District Council 37 Health & Benefit Fund.

If you are not currently enrolled in the Plan and wish to re-enroll or if you want to make changes to your health insurance, you must complete and submit the Funds Enrollment Form to your agency's Human Resource Administrator for eligibility verification. This must be received by the Fund Office no later than March 21, 2025, or you will have to wait until next year's open enrollment period.

Enclosed, you will find open enrollment materials that describe in Plan. Please read the enclosed materials carefully, as there are specific actions that you are required to take during this open enrollment period. Please note this is the only time the Fund will recognize your benefit selections unless you meet certain Special Enrollment Events, which are described in more detail in the enclosed material.

2025 Medical Plan Highlights in effect:

Office visit co-payment to $30 (non-hospital and surgical).
Specialist visit co-payment to $35 per visit.
Emergency Room co-payment to $150 per visit, waived if admitted.
Urgent Care visit co-payment to $50 per visit.

Open Enrollment

March 1 through March 21, 2025

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

Table of Contents

Open Enrollment
March 1 - 21 2025

If you are currently enrolled in the Plan and do not want to make changes to your current coverage, no action is necessary. Your current elections will roll over and continue into the benefit period effective April 1, 2025.

If you are not currently enrolled in the Plan and want to enroll or if you're going to make changes to your benefit elections, complete and submit the enclosed Enrollment/ Change form or Enrollment Waiver form. If your enrollment is not received during the open enrollment period, you will have to wait until next year's open enrollment to apply for coverage.

Please note this is the only time you will be allowed to change your benefit elections without experiencing a Special Enrollment Events that will make you eligible for the Plan. View page one (1) for more information on Special Enrollment Events.

Open Enrollment Elections Become Effective April 1, 2025

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

ENROLLING IN THE PLAN

How to Enroll

If you are currently enrolled in the Plan and ***do not want to make changes*** to your current coverage, ***no action is necessary***. Your current elections will roll over and continue into the new benefit period beginning **Januray 1, 2025**.

If you are not currently enrolled in the Plan and want to join or if you're going to make changes to your health insurance benefit elections, you **MUST** complete and return to your agencies Human Resources an Enrollment/Change form included in this packet. The Fund Office must receive your election by March 21, 2025. Please follow the instructions carefully.

Once you have made your elections, you will not be able to make changes to your benefits until the next open enrollment period unless you experience a **Special Enrollment Event** that makes you eligible for the Plan.

Action is Required!

If you are not currently enrolled in the Plan and want to join or if you're going to make changes to your benefit elections, you must complete and return the Enrollment Change form to your agency. The Fund Office must receive your changes by March 21, 2025. The effective date of any changes is April 1, 2025.

If you do not require coverage, you must complete and return a Health insurance Waiver form.

What Happens if I Don't Enroll

If your enrollment received during the open enrollment period, you would have to wait until the next year's open enrollment period to apply for coverage.

Special Enrollment Events

Loss of Eligibility for Other Coverage
If you declined enrollment for you or your dependents (including your spouse) in the Plan, and you sign this enrollment waiver form, you may be able to enroll your dependents and you in the Plan if you or your dependents subsequently lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' coverage). You must request special enrollment within 60 days of the loss of eligibility.

Marriage, Birth, Adoption, or Placement for Adoption
You, your spouse, and your new dependents may be permitted to enroll because of marriage, birth, adoption, or placement for adoption. You must request special enrollment within 60 days of the event.

Eligibility or Loss of State Assistance
A Special enrollment right also arises for you and your dependents who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or who are eligible to receive premium assistance under those programs. You must request special enrollment within 60 days of the loss of eligibility.

Questions?

For questions about member eligibility, please contact the Health Fund at 212-334-0096.

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

WHO IS ELIGIBLE FOR WELFARE FUND BENEFITS

Your Eligibility

You are eligible for Fund coverage if you are an employee of an agency covered by a Collective Bargaining Agreement between District Council 37 and your employer, and contributions to the Fund are required on your behalf. Coverage begins on the first day of the month following the completion of the required waiting period of employment with your agency.

Your Dependents' Eligibility

Generally, coverage for your dependents begins at the same time your coverage begins, provided they have been enrolled in the Plan, and contributions to the Fund are being made on their behalf.
Your eligible dependents are:

- Your spouse (a partner to a marriage legally recognized in the jurisdiction in which it is performed), unless legally separated.
- Your domestic partner*, who is:
  - at least 18 years of age;
  - neither married to you or any other person nor related to you by blood in a manner that would bar marriage in New York State;
  - someone with whom you have a close committed personal relationship; and
  - someone with whom you currently live and have been living with continuously.
- Your children whether or not married, until they reach age 26;
  - Group health insurance benefits are available to eligible dependents until the dependent reaches age 26, regardless of their student status, financial dependency, residency, employment or any combination of those factors, except that, before January 1, 2014, if the dependent is eligible to receive coverage under a group health plan of the dependent's employer, the dependent will not be eligible for coverage under the Fund's health insurance benefits.
  - Under Michelle's law, a dependent student on a medically necessary leave of absence will continue to be eligible covered for 12 months. This rule will apply to your dependent only if the period of coverage under Michelle's law is greater than the coverage provided to eligible dependents until age 26.
  - Your child's spouse and your child's children (your grandchildren) do not qualify for coverage.
- Your unmarried children, regardless of age, who are unable to support themselves because of a physical or mental disability (all as defined under the New York Mental Hygiene Law), provided the incapacitating condition started before age 23;

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

WHO IS ELIGIBLE FOR WELFARE FUND BENEFITS?

- Your adopted children from the moment of birth, provided that you take custody of the infant as soon as the infant is released from the hospital after birth and an adoption petition is filed with New York State within 30 days of the infant's delivery, even if the adoption is not yet final. However, adopted newborns will not be covered from the moment of birth if: (1) the health insurance of the child's natural parents covers the newborn's initial hospital stay; (2) a notice revoking the adoption has been filed; or (3) one of the natural parents revokes their consent to the approval.

For purposes of eligibility, your dependent children include your stepchildren and the children of your domestic partner.

Your foster children are not eligible for coverage.

* To enroll a domestic partner under a benefit plan offered through the Fund, you must present proof evidencing financial interdependence for at least 12 months and provide a copy of a signed and notarized Declaration of Domestic Partnership to the Fund. Contact the Fund office at 212-334-0096 for more information about Domestic Partner benefits.

Adding Eligible Adult Dependents

To add eligible dependents under age 26, who are not currently participating in the Plan to your health insurance, you must complete and return the Adult Dependent Election and Eligibility form to your center bookkeeper. Adult Dependent Election and Eligibility forms can be obtained by calling the Fund office at 212-334-0096

TYPES OF COVERAGE

Coverage Available

- **Employee:** covers the employee only.
- **Family:** covers the employee, their legal spouse or domestic partner, and their child or children.

The Anthem Blue Cross Blue Access network benefit

offers members exceptional provider choice through an extensive network, with no referrals to specialists needed, and access to medical practitioners and acute care hospitals as well as access to physicians and hospitals available.

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

WAIVING OUT OF THE PLAN

You may waive-out of enrollment in the Fund and its benefits if you are enrolled in another insurance plan or qualify for other assistance by providing the enclosed Enrollment Waiver form signed and returned to your agency for processing. Your waiver in the Fund and its benefits will be effective July 1, provided that we receive the Enrollment Waiver Form within the required deadline.

If you decide to waive participation in the Fund, you will not be able to join the health insurance plan at a later date until the next open enrollment period unless you experience a Special Enrollment Event that would allow you the opportunity to enroll.

PERMITTED ELECTION CHANGE EVENTS

Change in Status
Qualifying changes in status include events that change your legal marital status or the number of your dependents. Qualifying changes in status also include the following events that cause you, your spouse, or your dependent to become (or cease to be) eligible under the Plan: changes in employment status; a change in place of residence; and your dependent attaining a certain age or any similar circumstance.

Significant Cost or Coverage Changes
A change in cost means a significant increase or decrease in your price for an option offered under the Plan that occurs during the year. A change in coverage means the addition of a new benefit option, the elimination of an existing benefit option, or a significant difference in a current benefit under the Plan, or the Plan in which your dependents is enrolled.

Judgment, Decree, or Order
If a court has ordered you to cover a spouse or minor children, you must add the spouse and minor children as directed in the court order.

Loss of Entitlement to Medicare or Medicaid
If you, your spouse, or your dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, may be permitted to enroll or increase coverage for the same individual under the Plan.

If you have any questions regarding this, please contact the Fund office at 212-334-0096.

**** All election changes or special enrollments must be received within 60 days, or you will be required to wait until the next year's open enrollment.***

If you do not require coverage, you must sign the health insurance Waiver Form and return the form to your agency. The Fund must receive all waivers by March 21, 2025.

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

Anthem Blue Cross Blue Access In-Network Summary of Health Insurance Benefits

Member Service Phone Number: 1-844-241-6224
Provider Website: www.anthembluecross.com

Benefit Highlights			
	Office or Free-Standing Facility	**In-Network**	**Out-of-Network**
	Office Visit Copay	$ 30 Copay	70% of eligible expenses*
	Specialist Visit Copay	$ 35 Copay	70% of eligible expenses*
	Urgent Care Visit Copay	$ 50 Copay	70% of eligible expenses*
	Diagnostic Lab Copay Per Visit	$ 30 Copay	70% of eligible expenses*
	Diagnostic Radiology Copay Per Visit	$ 100 Copay	70% of eligible expenses*
	Dependent Office Visit Copay	$ 30 Copay	70% of eligible expenses*
	Dependent Diagnostic Lab Copay Per Visit	$ 30 Copay	70% of eligible expenses*
	Dependent Diagnostic Radiology Copay Per Visit	$ 30 Copay	70% of eligible expenses*
	Individual Deductible	$ 0	$500
	Family Deductible	$ 0	$1,500
	Coinsurance	$ 0	30% **
	Individual Coinsurance Maximum	N/A	N/A
	Family Coinsurance Maximum	N/A	N/A
	Emergency Room Facility Copay	$ 150 Copay	70% of eligible expenses*
	Emergency Room Professional Charge	$ 0	70% of eligible expenses*
	Dependent Child Age	Age 26 EOM	Age 26 EOM

Inpatient Hospital Services Performed and Billed by a Hospital

	Limitations	**In-Network**	**Out-of-Network**
Inpatient Hospital Coverage Insurance r	PRE CERT: YES	$ 100 Copay	70% of eligible expenses*
Skilled Nursing Facility Care	PRE CERT: YES	None	70% of eligible expenses*
Inpatient Admission for Medical Rehabilitation (i.e. PT, Physical Medicine and Rehabilitation)	PRECERT: YES 30 days per calendar year	None	70% of eligible expenses*
Hospice Care	PRE CERT: YES 210 days per lifetime		

Open Enrollment is
March 1 – March 21, 2025

If you are not currently enrolled in the plan and want to enroll or if you want to make changes to your benefit elections, you must complete and return the open enrollment documents included in this packet to your agency Human Resource Administrator and returned to the Fund Office by March 21, 2025.

Anthem Blue Cross Blue Access In-Network Summary of Health Insurance Benefits

Member Service Phone Number: 1-844-241-7089
Provider Website: www.anthembluecross.com

Inpatient Mental Health & Chemical Dependency			
	Limitations	**In-Network**	**Out-of-Network**
Inpatient Mental Health	PRE CERT: YES	$ 100 per admission	70% of eligible expenses*
Chemical Dependency: Detoxification	PRE CERT: YES	$ 100 per admission	70% of eligible expenses*
Chemical Dependency: Rehabilitation	PRE CERT: YES	$ 100 per admission	70% of eligible expenses*
Outpatient Mental Health & Chemical Dependency in an office visit setting			
	Limitations	**In-Network**	**Out-of-Network**
Outpatient Chemical Dependency2		$ 30 Copay	70% of eligible expenses*
Outpatient Mental Health2		$ 30 Copay	70% of eligible expenses*
Prescription Coverage			
	Limitations	**Retail Rx Tier 1 / Tier 2 / Tier 3**	**Mail Order Rx Tier 1 / Tier 2 / Tier 3**
Rx Copay		*$10 Generic or 25% lesser of the cost. *$20 Brand or 25% lesser of the cost. *$30 Non-Preferred Brand or 25% lesser of the cost.	*$25 Generic or 25% lesser of the cost. *$50 Brand or 25% lesser of the cost. *$75 Non-Preferred Brand or 25% lesser of the cost.

*The greater of $25 Brand-Preferred / $50 Non-Preferred or 25% of the cost of the medication. If there is a Generic equivalent, the member's share will be the co-pay plus the difference in the price between the Generic and Brand drug. The Emergent Charge is 100% at 90%ile of Fair Health. Members are responsible for any applicable cost-sharing including the difference between
Anthem Blue Cross Blue Access's payment and a Non-Participating / Non-Network Provider's charge.
1 – Non-Participating providers in a network hospital, facility, OPD, ambulatory facility or office are subject to the Non-Emergent Charge 100% at 90%ile of Fair Health. Members are responsible for any applicable cost-sharing, including the difference between payment and a Non-Participating / Non-Network Provider's charge. The benefits described here are only brief highlights of the coverage available. The terms, limitations, conditions, and exclusions of the Plan will govern. For specific details, refer to the Plans Summary Plan Description for complete detail. Contact the Fund Office to receive a copy at 212-334-0096.

District Council 37 Health & Benefit Fund

Summary of Benefits

Eligibility: Eligible dependents are your lawful spouse, domestic partner, and your dependent children up to age 26 (without employer sponsored coverage).

In-Network Benefits

Hospital Charges	Co-Pay	Benefit
Semi-Private Room & Board	$ 100 per admission	Up to 120 days covered in full. Charges from 121st day covered under Major Medical.*
Ambulatory Surgery	$ 70	Covered in full*
Emergency Room	$ 150, waived upon admission	Covered in full*
Mental Health Inpatient	$ 100 per admission	Up to 120 days covered in full. Charges from 121st day covered under Major Medical.*
Substance Abuse	None	Up to 120 days covered in full. Charges from 121st day covered under Major Medical.*
Pre-admission testing	None	Covered in full*
In-patient Physical Rehabilitation	None	Covered in full*
(Limited to 7 days following acute in-patient hospital stay. Pre-certification required.)		

*OUTPATIENT CARE : The following benefits are available through the Empire BCBS Network**

	Empire Blue Cross Blue Access EPO Network	Out-of-Network - Major Medical
Deductible	NONE	**$ 500** Per Individual, per calendar year. The Annual Family Deductible Maximum is $ 1,500.
Coinsurance	Not Applicatible	**Effective 01/01/2010 the Fund will adopt a schedule of reimbursement based on 120% of the Medicare reimbursement schedule. The Fund reimbursement of 70% will not change in addition to appliable deductibles.**
Physician Services		
Office Visit	$ 30 co-pay	Subject to deductible and 70% of eligible expenses
Specialist Care	$ 35 co-pay	Subject to deductible and 70% of eligible expenses
Urgent Care	$ 50 co-pay	Subject to deductible and 70% of eligible expenses
Surgery	Covered in full	Subject to deductible and 70% of eligible expenses
Diagnostic Tests & X-Ray	$ 30 co-pay	Subject to deductible and 70% of eligible expenses
Outpatient Diagnostic Tests	$ 30 co-pay	Subject to deductible and 70% of eligible expenses
Outpatient Hospital Diagnostic Tests (i.e. MRI's, CT Scans, Lab & X-ray Services)	$ 100 co-pay	Subject to deductible and 70% of eligible expenses
Acupuncture Licensed M.D. or D.O. only	$ 30 co-pay Limited to 18 visits per calendar year.	Subject to deductible and 70% of eligible expenses Limited to 18 visits per calendar year.
Chiropractic	$ 30 co-pay Limited to 18 visits per calendar year.	Subject to deductible and 70% of eligible expenses Limited to 18 visits per calendar year.
Out-patient Physical Therapy	$ 30 co-pay Limited to 15 visits per calendar year.	Subject to deductible and 70% of eligible expenses Limited to 15 visits per calendar year.
Mental Health		
Out-patient	$ 30 co-pay per visit	Subject to deductible and 70% of eligible expenses

Life-Insurance (Non Negotiated Benefit) $ 15,000 Basic Life / Accidental Death & Dismemberment

Prescription Drug Card	Covered under Epiphany Rx
Retail Pharmacy Generic	The greater of $ 10 or 25% lesser of cost
Retail Pharmacy Preferred Formulary Drug (see enclosed list)	The greater of $ 20 or 25% lesser of cost
Retail Pharmacy Non-Preferred Formulary Drug	The greater of $ 30 or 25% lesser of cost
Mail Order Generic (3 month supply)	The greater of $ 25 or 25% lesser of cost
Mail Order Preferred Formulary (3 month supply)	The greater of $ 50 or 25% lesser of cost
Mail Order Non-Preferred Formulary (3 month supply)	The greater of $ 75 or 25% lesser of cost

Dental (In-Network Only)

Benefits are availalbe through the CIGNA-DHMO plan.

***Intended as a Benefit Summary only, specific details refer to the Plan Booklet (SPD) for complete benefits.**

February 2025

District Council 37 Health & Benefit Fund

420 West 45th Street, 3rd Floor, New York, NY 10036
Tel.: (212) 334-0096 Fax: (212) 274-0104

Enrollment Form

Member's Information *(Please Print or Type)*

LastName:	First Name:	M.I.:
Mailing Address : ***Street***		***Apartment***
City	***State***	***Zip***
Soc. Sec. No.:	Birth Date:	Gender:
Phone Number:	Email:	
Relationship: ***Member***	Do you want Family Coverage? YES / NO	
Marital Status: [ ] Single	[ ] Married *(Date:)*	[ ] Divorced [ ] Widowed
Agency / Employer:		Hire Date:
Are you currently covered through another medical plan? YES / NO		Is this Family Coverage? YES / NO
If "YES", Name of Insurance:		Policy ID:
Effective Date:	Termination Date:	Is this COBRA Coverage? YES / NO

Spouse's Information *(Please Print or Type)*

LastName:	First Name:	M.I.:
Address: *(If different from Member's address)*		
Soc. Sec. No.:	Birth Date:	Phone No.:
Gender:	Relationship:	Is your spouse currently employed? YES / NO
Current Employer:	Hire Date:	Phone No.:
Is your spouse currently covered through another medical plan? YES / NO		Is this Family Coverage? YES / NO
If "YES", Name of Insurance:		Policy ID:
Effective Date:	Termination Date:	Is this COBRA Coverage? YES / NO

Dependent Child's Information *(Please Print or Type)*

1st	LastName:	First Name:	M.I.:
	Address: *(If different from Member's address)*		
Soc. Sec. No.:		Birth Date:	Phone No.:
Gender:	Relationship:		Is this dependent currently employed? YES / NO
Current Employer:		Hire Date:	Phone No.:
Is this dependent currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO
If "YES", Name of Insurance:			Policy ID:
Effective Date:	Termination Date:		Is this COBRA Coverage? YES / NO

Continued on Back

Continued from Front

Dependent Child's Information *(Please Print or Type)*

2nd

LastName: First Name: M.I.:

Address: *(If different from Member's address)*

Soc. Sec. No.: Birth Date: Phone No.:

Gender: Relationship: Is this dependent currently employed? YES / NO

Current Employer: Hire Date: Phone No.:

Is this dependent currently covered through another medical plan? YES / NO Is this Family Coverage? YES / NO

If "YES", Name of Insurance: Policy ID:

Effective Date: Termination Date: Is this COBRA Coverage? YES / NO

3rd

LastName: First Name: M.I.:

Address: *(If different from Member's address)*

Soc. Sec. No.: Birth Date: Phone No.:

Gender: Relationship: Is this dependent currently employed? YES / NO

Current Employer: Hire Date: Phone No.:

Is this dependent currently covered through another medical plan? YES / NO Is this Family Coverage? YES / NO

If "YES", Name of Insurance: Policy ID:

Effective Date: Termination Date: Is this COBRA Coverage? YES / NO

4th

LastName: First Name: M.I.:

Address: *(If different from Member's address)*

Soc. Sec. No.: Birth Date: Phone No.:

Gender: Relationship: Is this dependent currently employed? YES / NO

Current Employer: Hire Date: Phone No.:

Is this dependent currently covered through another medical plan? YES / NO Is this Family Coverage? YES / NO

If "YES", Name of Insurance: Policy ID:

Effective Date: Termination Date: Is this COBRA Coverage? YES / NO

*** * * IMPORTANT * * ***

If you and/or member of your family become covered by another insurance plan or terminate from your other insurance plan, please notify us in writing of any change, including Effective or Termination Date.

I certify that all the answers on this application are true to the best of my knowledge and belief. I further understand that any false statement may disqualify me for any benefits, and the Trustees of the Fund shall have the right to recover any payments made to me in reliance upon any false statement.

Member's Signature: Date:

Office Use Only

Coverage

Effective Date: _____

Termination Date: _____

Life Insurance: $_____

Employer ID No.: _____

Medical: Single / Family

Hospital: Single / Family

Rx Drug: Single / Family

Optical: Single / Family

Dental: Single / Family

[ ] New Enrollment
[ ] Re-instatement
[ ] Name Change
[ ] Address Change
[ ] Status Change
[ ] Benefit(s) Change
[ ] Adding Dependent(s)
[ ] Other:

ENROLLMENT FOR LIFE INSURANCE

PLEASE TYPE OR PRINT

EMPLOYER POLICYHOLDER'S NAME: **DISTRICT COUNCIL 37**
HEALTH & BENEFIT FUND

EMPLOYEE INSURED'S NAME:	*(Last)*	*(First)*	*(Middle Initial)*
STREET:			
CITY:	**STATE:**	**ZIP CODE:**	
Social Security #:	**Date of Birth:** *(Month)* *(Day)* *(Year)*		
Telephone #:	**Place of Birth:** *(City, State)*		
EMPLOYER:		**Hire Date:**	

Beneficiary Designation
(Please indicate a Primary and Contingent beneficiary)

PRIMARY
The proceeds shall be divided equally among those of the following designated person or persons who survive the insured.

1	Name	Relationship
	Address, City, State, Zip-Code	
2	Name	Relationship
	Address, City, State, Zip-Code	

CONTINGENT
The proceeds shall be divided equally among those of the following designated person or persons who survive the insured provided no primary beneficiary designated above has survived the insured.

1	Name	Relationship
	Address, City, State, Zip-Code	
2	Name	Relationship
	Address, City, State, Zip-Code	

I understand that this coverage shall become effective only if this application is accepted.

Signature _____ **Date** _____

RETURN TO:

District Council 37 Health & Benefit Fund
420 West 45th Street, 3rd Floor
New York, NY 10036

Revision Date : July 2022

District Council 37 Health & Benefit Fund

420 West 45th Street, 3rd Floor, New York, NY 10036
Tel: (212) 334-0096 Fax: (212) 274-0104

ENROLLMENT WAIVER

I, the undersigned, hereby certify that I have been afforded an opportunity to enroll in the Group Health Benefits offered by DC 37 Health & Benefit Fund (the "Plan"). After careful consideration, I have decided to not enroll in the Plan, thereby waiving my right to such coverage.

I understand that I will not be able to enroll in the Plan at a later date unless I enroll during Open Enrollment, or I experience either (1) a Special Enrollment Event or (2) a Permitted Election Change Event (if adopted under the terms of the Plan), if I provide the Plan's benefit office notice of an event within 60 days of occurrence. I certify that I have read and understand the attached Special Enrollment Events and Permitted Election Change Events that allow me to enroll in the Plan outside of Open Enrollment. Further, I understand that to prove I experienced such an event I must provide supporting documents as outlined in the Summary Plan Description ("SPD").

Note: Special Enrollment Events and Permitted Election Change Events that allow you to enroll, cancel, or otherwise change your coverage are described at length in the SPD, but the event's that permit you and your dependents to enroll in the Plan outside of Open Enrollment are summarized in the attached form. Please refer to your SPD for important deadlines and procedures to request enrollment, cancellation, or changes to your coverage.

I decline enrollment in the DC 37 Health & Benefit Fund because:

☐ Covered under another health plan; ☐ Other (_____).
Please mark the appropriate reason for waiving coverage. If "Other", please explain.

_____ _____
Employee Signature Date

_____ _____
Print Name Telephone Number

_____
Home Address

To be completed by Human Resources Department

Agency Name _____

Above is certified by

Print Name _____ Title _____

Signature _____ Date _____

Please keep copy and mail original form to:

DC 37 Health & Benefit Fund
420 West 45 th Street, 3rd Floor
New York NY 10036

District Council 37 Health & Benefit Fund

420 West 45th Street, 3rd Floor, New York, NY 10036
Tel: (212) 334-0096 Fax: (212) 274-0104

SPECIAL ENROLLMENT EVENTS

Loss of Eligibility for Other Coverage
If you declined enrollment for you or your dependents (including your spouse) in the Plan, and you sign this enrollment waiver form, you may be able to enroll your dependents and you in the Plan if you or your dependents subsequently lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Marriage, Birth, Adoption or Placement for Adoption
You, your spouse and your new dependents may be permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

Eligibility or Loss of State Assistance
A special enrollment right also arises for you and your dependents who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or who are eligible to receive premium assistance under those programs.

PERMITTED ELECTION CHANGE EVENTS

Change in Status

Qualifying changes in status include events that change your legal marital status or the number of your dependents. Qualifying changes in status also include the following events that cause you, your spouse, or your dependent to become (or cease to be) eligible under the Plan: changes in employment status; a change in place of residence; and your dependent attaining a certain age or any similar circumstance.

Significant Cost or Coverage Changes

A change in cost means a significant increase or decrease in your cost for an option offered under the Plan that occurs during the year. A change in coverage means the addition of a new benefit option, the elimination of an existing benefit option, or a significant change in an existing benefit under the Plan, or the plan in which your dependents (including your spouse) are enrolled.

Judgment, Decree, or Order

If a court has ordered you to cover a spouse or minor children, you must add the spouse and minor children as directed in the court order.

Loss of Entitlement to Medicare or Medicaid

If you, your spouse, or your dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, you may be permitted to enroll or increase coverage for the same individual under the Plan.

SUPPORTING DOCUMENTS MUST BE PROVIDED TO PROVE THESE EVENTS OCCURRED

You must notify the Plan's benefit office if one of the events occur to you within 60 days of it happening in order to be eligible for re-enrollment.

District Council 37 Health & Benefit Fund

Coverage Period: 04/01/2025-03/31/2026

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual or Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered healthcare services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, call 1-212-334-0096. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-833-440-8480 to request a copy. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description or by calling the Fund office at 1-212-334-0096 or Anthem BC Blue Access at 1-844-241-7089.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	No deductible for in-network services. $500 individual/$1,500 family deductible for out-of-network services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	No deductible for in-network. $500 individual/$1,500 family **deductible** for out-of-network services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No deductible for in-network. $500 individual/$1,500 family **deductible** for out-of-network services.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	There is no **out-of-pocket** limit for this plan.	The **Out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Services that are excluded from coverage.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Will you pay less if you use a network provider?	Yes. In-Network benefits, you will only pay a co-pay.	The out-of-network benefits are subject to **deductible** plus co-insurance and balance billing.
Do you need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.

- Co-payment are fixed dollar amounts (for example, $10) you pay for covered health care, usually when you received the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 30% would be $300. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amounts is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$ 30 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Specialist visit	$ 35 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Preventive care/screening/ immunization	No Charge	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you have a test	Diagnostic test (x-ray, blood work)	$ 30 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Imaging (CT/PET scans, MRIs)	$ 100 co-pay / visit	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.procarerx.com or (800) 699-3542.	Generic drugs	The greater of a $25 co-pay or 25% of the cost of the medication	Not Covered	It covers up to 30 days of supply for retail and 90 days for mail orders.
	Preferred brand drugs	The greater of $20 co-pay or 25% of the cost of the medication	Not Covered	It covers up to 30 days of supply for retail and 90 days for mail orders.
	Non-preferred brand drugs	The greater of $30 co-pay or 25% of the cost of the medication	Not Covered	It covers up to 30 days of supply for retail and 90 days for mail orders.
	Specialty drugs	The greater of $30 co-pay or 25% of the cost of the medication	30% co-insurance	It covers up to 30 days of supply for retail and 90 days for mail orders.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$ 70 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Physician/surgeon fees	$ 0 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you need immediate medical attention	Emergency room care	$ 150 co-pay	30% co-insurance	Waived if admitted.
	Emergency medical transportation	$ 0 co-pay	30% co-insurance	Maximum allowance ALS $1,290 BLS $704 plus $12 per mile transport.
	Urgent care	$ 50 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Physician/surgeon fees	$ 0 co-pay	30% co-insurance	Allowed one visit per day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services office visit.	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Inpatient services	$100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Substance use disorder outpatient services office visit.	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Substance use disorder inpatient services	$ 100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If you are pregnant	Office visits	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Childbirth/delivery professional services	$ 0 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Childbirth/delivery facility services	$100 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$ 0 co-pay	30% co-insurance	Maximum 90 visits per year. Pre-authorization required.
	Rehabilitation services	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Habilitation services	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Skilled nursing care	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Durable medical equipment	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
	Hospice services	$ 30 co-pay	30% co-insurance	Plus the difference between the Plans allowance and billed Provider charges.
If your child needs dental or eye care	Children's eye exam	$ 0 co-pay / visit	Schedule	Limited to one exam every 24 months.
	Children's glasses	$ 0 co-pay	Schedule	Limited to one pair of glasses every 24 months.
	Children's dental check-up	No Charge	Not Covered	If enrolled in Dental HMO.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Motor vehicle related expenses
- Infertility treatment
- Long-term care
- Medical care when traveling outside the U.S.
- Private-duty nursing
- Hearing aids
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Dialysis (in-network only)
- Chiropractic care
- Dental Care
- Organ transplants (requires prior approval)
- Vision care
- Routine medical checkup
- Chemotherapy

Your Rights to Continue Coverage:

** Individual health insurance sample -

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you or your employer pay the premium. There are exceptions, however, such as if:

- You commit fraud
- The Fund Stops offering services
- you move outside the coverage area

For more information on your rights to continue coverage, contact the Fund at 1-212-334-0096. You may also contact your state insurance department.

Group health coverage -

If you lose coverage under the plan, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-212-334-0096. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-844-241-7089.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-241-7089.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-241-7089.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-241-7089.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *Co-payment*	$35
Hospital (facility) *Co-payment*	$100
Other *Co-insurance*	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$235

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *Co-payment*	$35
Hospital (facility) *Co-payment*	$100
Other *Co-insurance*	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	$235

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *Co-payment*	$35
Hospital (facility) *Co-payment*	$100
Other *Co-insurance*	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Mia would pay is	$235

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would received for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Example to compare plans?

✓ Yes. When you look at the Summary of the Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of pocket expenses.