125 Barclay Street
New York, N.Y. 10007-2179
Telephone: (212) 815 - 1234

DC37 Health & Security Plan

November 2017

Dear Local 1070 NYS Active/Retired Member:

Together with DC37 Local 1070 President Fausto Sabatino, the DC37 Health & Security Plan (the Plan) is pleased to provide a prescription drug co-payment reimbursement benefit to all eligible members and retirees from the New York State Court System, represented by DC37 Local 1070.

For Calendar Year 2017, each eligible member or retiree will be eligible to receive a reimbursement for prescription drug co-payments of **up to** a maximum of $300 per family for any amount over $1. ***However, only one reimbursement request per family will be accepted for the prescription drug co-payment reimbursement during Calendar Year 2017.***

The following examples explain how the reimbursement is determined:

> *If the total out-of-pocket prescription drug co-payment for you and your family for the period of January 1, 2017 through December 31, 2017 was $150; you will be eligible to receive a reimbursement payment of $150.*
>
> *If the total out-of-pocket prescription drug co-payment for you and your family for the period of January 1, 2017 through December 31, 2017 was $400; you will be eligible to receive a reimbursement payment of $300, the maximum benefit amount.*

Please complete the enclosed application form and submit it for payment along with an Explanation of Benefits (EOB) statement from your prescription drug benefit provider documenting your total out-of-pocket prescription drug co-payments for the calendar year 2017. The EOB statement must be attached to the application. Your application will not be processed without the EOB statement. The application and EOB statement must be returned to the Health & Security Plan's office, in the enclosed self-addressed envelope, **no later than April 30, 2018**.

You can contact the New York State Health Insurance Program (Empire Plan: 1-877-769-7447) or your HMO for information on how to request an Explanation of Benefits statement reflecting your year-end total prescription drug co-payments. You may also be able to request this statement directly from your prescription drug benefit provider's website.

If you have any questions regarding this benefit, please contact the DC37 Health & Security Plan's Inquiry Unit (212-815-1234).

In Solidarity,

Willie Chang
Administrator

DC 37 Health & Security Plan
125 Barclay Street
New York, New York 10007-2179

NEW YORK STATE COURT SYSTEM EMPLOYEES AND RETIREES REPRESENTED BY LOCAL 1070

PRESCRIPTION DRUG CO-PAYMENT REIMBURSEMENT CLAIM – 2017

Last Name: _____ First Name: _____ M.I.____

Address: _____ Apt. No.: _____ City: _____

State: _____ Zip Code: _____ Daytime Telephone No.: _____

Please check one: _____Active Local 1070 member _____Retiree of Local 1070

Personal Identification Number (PID) or SS#_____

Signature: _____ Date: _____

TO THE ELIGIBLE MEMBER OR RETIREE: To obtain your reimbursement of out-of-pocket prescription drug co-payments of up to a maximum of $300 per individual/family for the period January 1, 2017 through December 31, 2017, please do the following: 1) fully complete and sign the above application; 2) attach to this form a copy of your Explanation of Benefit Statement (EOB) obtained from your prescription drug benefit provider (Empire Plan or your HMO) documenting your total co-payments for the calendar year 2017; and, 3) send both to the DC 37 Health & Security Plan, 125 Barclay Street, New York, New York 10007, Attn: Drug Unit. Applications submitted without an EOB statement **cannot be processed and will be returned to you** (individual receipts will not be accepted). To qualify for reimbursement, please submit your total out-of-pocket prescription co-payments over $1 for Calendar Year 2017. The Health & Security Plan will reimburse you up to a maximum of $300 in out-of-pocket prescription drug co-payment expenses. All applications for reimbursement must be received no later than April 30, 2018. For assistance in completing this application you may contact the Plan's Inquiry Unit at (212) 815-1234.

(This section to be completed by DC37 H&S Plan staff only)

EOB attached: ____ YES ____NO
Total prescription drug co-payment:_____ Reimbursement Amount: _____
Prepared by: _____ Date: _____
Reviewed/Approved By: _____ Date: _____
Date sent to Accounting: _____