

55 Water Street, 23<sup>rd</sup> Floor  
New York, NY 10041  
Telephone :( 212) 815-1234

# Health & DC37 Security Plan

December 2022

**RE: Local 1070 Prescription Drug Co-Payment Reimbursement Benefit**

Dear Local 1070 NYS Active/Retired Bargaining Unit Member:

DC37 Local 1070 and the DC37 Health & Security Plan (the “Plan”) are pleased to provide a Prescription Drug Co-Payment Reimbursement Benefit to all eligible bargaining unit members and retirees (“Participant(s)”) from the New York State Court System who are represented by DC37 Local 1070.

For Calendar Year 2022, Participants may receive reimbursement for prescription drug co-payments up to a maximum of \$300 per family when they spend at least \$1. ***Only one reimbursement request per family is permitted..***

For example:

*If the total out-of-pocket prescription drug co-payment for you and your family for the period from January 1, 2022 to December 31, 2022 was \$150, you are eligible for a reimbursement of \$150.*

*If the total out-of-pocket prescription drug co-payment for you and your family for the period from January 1, 2022 to December 31, 2022 was \$400, you are eligible for a reimbursement of \$300, which is the maximum benefit amount.*

Please complete the enclosed application 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 2022. 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 Plan’s office, in the enclosed self-addressed envelope **no later than April 30, 2023.**

Please contact the New York State Health Insurance Program (Empire Plan: 1-877-769-7447) or your HMO for information on how to obtain 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 Drug Unit at 212-815-1621.

In Solidarity,

*William Bifulco*

William Bifulco

Administrator

DC37 Health and Security Plan

cc: Renee Belmar, President – Local 1070



**DC 37 Health & Security Plan  
55 Water Street, 23<sup>rd</sup> Floor  
New York, NY 10041**

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

**PRESCRIPTION DRUG CO-PAYMENT REIMBURSEMENT CLAIM – 2022**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Daytime Telephone No.: \_\_\_\_\_

Please check one:     \_\_\_\_\_ Local 1070 Active Bargaining Unit Member  
                                  \_\_\_\_\_ Local 1070 Retiree

Personal Identification Number (PID) or SS# \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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To obtain your reimbursement of out-of-pocket prescription drug co-payments per individual/family for the period January 1, 2022 through December 31, 2022, please: 1) Complete and sign the above application; 2) Attach 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 2022; and, 3) Send both to the DC 37 Health & Security Plan, 55 Water Street, 22nd Floor, New York, New York 10041, 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 2022. 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 29, 2023**. For assistance in completing this application you may contact the Plan's Drug Unit at (212) 815-1621.

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(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: \_\_\_\_\_