# Detectives' Endowment Association, Inc.
# Police Department, City of New York

## Health Benefits Fund

## Comprehensive Benefits Booklet

# Active Member Benefits

Dear Member:

The Trustees are pleased to provide you with this Comprehensive Benefits Booklet which describes your benefits through the Detectives' Endowment Association Health Benefits Fund.

This booklet includes all the Trust Fund benefits--prescription drug, dental, optical, hearing aid and body scans. This booklet contains details of these benefits including enrollment, eligibility, coverage for dependents, and other general information concerning Trust Fund procedures. To the extent that this booklet describes an insured benefit, the group insurance contract specifies the exact benefits provided, and the language of the insurance contract will govern in the event of inconsistency between it and the language of this booklet.

We suggest that you read this booklet carefully and share it with your family. Please keep it available so that you can refer to it in the future.

If you have any questions, please contact the Fund Office at **212.587.9120**.

Yours truly,

Board of Trustees

Paul DiGiacomo, Chairman

Paul Morrison

Scott Munro

Jeffrey Ward

Frank Ciccone

# HEALTH BENEFITS FUND

## HEALTH BENEFITS FUND OF THE DETECTIVES' ENDOWMENT ASSOCIATION, INC. POLICE DEPARTMENT, CITY OF NEW YORK

26 Thomas Street
New York, New York 10007
212.587.9120
fax 212.587.9149

**Board of Trustees**

Paul DiGiacomo, Chairman

Paul Morrison

Scott Munro

Jeffrey Ward

Frank Ciccone

**Executive Director**

Carmine D. Russo

**Fund Administrator**

Sharon Robertson

**Fund Counsel**

Mirkin & Gordon, P.C.

**Fund Auditor**

Gould, Kobrick & Schlapp, LLP

# Table of Contents



This guide is an outline of your coverage based on information provided by the Fund and applicable insurance carriers. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts, where applicable, themselves must be read for those details. Policy forms for your reference will be made available upon request. Furthermore, the information in this guide should in no way be construed as a promise or guarantee of employment or benefits or legal advice. The Fund's Board of Trustees reserve the right to modify, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this guide and the actual plan documents or policies, the documents or policies will always govern.

# Benefits Offered

At Detectives' Endowment Association, Inc., our members are our most valuable assets and because of this, our benefit programs have been designed to make working life more enjoyable and rewarding and can offer valuable financial protection and resources when unexpected challenges occur. We are constantly reviewing our benefit offerings to ensure we are providing high-quality benefit programs that meet our members' needs. The following are highlights of our comprehensive benefits program.

- Dental
- Prescription
- Vision
- Hearing
- Equipment & Nursing
- Body Scan
- Aflac Supplemental Insurance
- Counseling

# Health Plan

## HEALTH PLAN ELIGIBILITY

## WHO IS ELIGIBLE FOR COVERAGE UNDER THE NYPD HEALTH PLAN?

### Eligible Members

All Detectives and Detective Investigators for whom the Detectives' Endowment Association Health and Welfare Fund (Fund) receives a contribution under Collective Bargaining Agreements with the City of New York are eligible for these benefits, provided they are actively employed. (Retirees should refer to the separate booklet for Retired Members.)

### Eligible Dependents

- ***Your spouse***, unless divorced or legally separated pursuant to a court decree.
- ***Your domestic partner*** – domestic partners are defined by the City of New York as two people, both whom are 18 years of age or older, neither of whom is married or related by blood in a manner that would bar marriage in New York, who have a close and committed relationship, who live together and have been living together on a continuous basis, who have registered as domestic partners and have not terminated the domestic partnership.

Persons may register as domestic partners if they are residents of the City of New York or at least one partner is employed by the City on the date of registration. In order to register, persons shall execute a domestic partnership registration certificate and submit it to the City Clerk.

In order to cover a domestic partners on your City health plan coverage, you must have a Domestic Partnership Registration Certificate issued by the City Clerk and provide acceptable evidence of financial interdependence as defined in the City's Declaration of Financial Interdependence.

After your application for City health plan coverage is approved and accepted, you will receive a letter from the City, which can be presented to the Fund to verify the eligibility of your domestic partner for coverage by the Fund. A qualified Domestic Partner becomes eligible on the date he or she is approved for coverage by the City health plan.

Alternatively, if you and your domestic partner have registered for domestic partnership in another municipality or state that recognizes domestic partnerships, you may provide the Fund with a copy of the domestic partnership certificate issued by said state/municipality as proof for coverage of your domestic partner by the Fund. Same sex couples that married in jurisdictions that recognize same-sex marriage or entered civil unions in jurisdictions that recognize such arrangements, may provide a copy of their marriage license or civil union certificate as proof of a domestic partnership to the Fund. Not related by blood or affinity.

# Health Plan (continued)

- ***Your dependent children (including legally adopted children)*** up until their 26th birthday.
- ***Stepchildren and children of domestic partners*** may be eligible for benefits provided that they are chiefly dependent upon you, the member, for support and maintenance and are enrolled with the Fund, by you, when you enroll or when they initially become your dependents. To establish eligibility of a member's step child or a domestic partner's child, an affidavit of dependency must be filed with the Fund verifying that the child resides full-time **with the member** and proof of financial dependency as shown by income tax returns. This affidavit is available at the Fund office.
- ***A child who is physically or mentally incapable of self-support*** and is an eligible dependent under the Fund's benefits plan upon attaining age 26 may be continued under the Plan while remaining so incapacitated and unmarried, subject to your own coverage remaining in effect. To continue a child under this provision, proof of incapacity must be received by the Fund within 31 days after coverage would otherwise terminate (due to the child attaining the age of 26). Additional proof will be required periodically.

**IN ORDER FOR YOUR ELIGIBLE DEPENDENTS TO BE COVERED BY THE FUND, YOU MUST SUBMIT COPIES OF THE FOLLOWING APPLICABLE DOCUMENTS:**

1. Social Security Card/Number;
2. Marriage Certificate;
3. Birth Certificate;
4. Letter from the City verifying enrollment of you domestic partner in your City health plan or a Domestic Partner Registration Certificate or Civil Union Certificate form an applicable jurisdiction;
5. Legal Adoption papers;
6. Legal Guardianship papers;
7. For physically or mentally disabled, dependent children are 26 and older: a letter from the child's medical carrier extending health benefits or from the child's physician stating the physical or mental incapacity, date of onset, and expected duration of disability.

# Health Plan (continued)

## SURVIVOR EXTENSION OF BENEFITS

### Death of Member—In the Line of Duty

If a covered member dies in the line of duty (classified by the New York City Police Pension Board) and he or she was covered by the City basic health plan at the time of death, the member's spouse or domestic partner and eligible dependents shall continue to be covered by the Fund until the earliest of the following events:

- The surviving spouse remarries or the domestic partner marries or enters a new domestic partnership or civil union, or
- Eligible dependent reaches his or her 26th birthday, or
- The surviving spouse or domestic partner becomes covered under a health plan other than the one provided by the City of New York.

If a covered member dies while on active military service, the Fund will treat such a death as in the line of duty for the purpose of extending benefits to the member's covered dependent(s).

### Death of Member—Outside of the Line of Duty

If a covered member dies outside of the line of duty, and he or she was covered by the City's basic health plan at the time of death and he or she had dependent children (natural or adopted only) enrolled in the Fund at the time of death, who were under age 19, then the member's spouse or domestic partner and natural or adopted children shall continue to be covered by the Fund until the earliest of the following events:

- The surviving spouse remarries or the domestic partner marries or enters a new domestic partnership, or
- The member's youngest child (natural or adopted) reaches his or her 19th birthday, or
- The surviving spouse or domestic partner becomes covered under a health plan other than the one provided by the City of New York.

# Health Plan (continued)

## AMENDMENT AND TERMINATION OF BENEFITS

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust Agreement which established the Fund and governs its operations.

Your coverage and your dependents' coverage will end on the earliest of the following dates:

- If and when the Fund is terminated.
- When you are no longer eligible.
- When there is non-payment of the direct pay premiums for COBRA continuation of coverage.
- When the Employer ceases to make contributions on your behalf to the Fund.

Your dependents' coverage will also terminate when they are no longer eligible dependents.

Member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits. The Trustees may expand, modify or cancel the benefits for members and dependents; change eligibility requirements or the amount of the self-pay premiums; and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.

## THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled, to the extent it pays out benefits, to reimbursement from the covered member or dependent from any recovery obtained from the responsible third party (including Workers' Compensation cases). Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim recovery against the third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

- To reimburse the Fund, to the extent of benefits paid to it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise;
- To provide the Fund with an Assignment of Proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund in seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; and

# Health Plan (continued)

- To take all reasonable steps to effect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

## BENEFITS PAYABLE ON BEHALF OF DECEASED MEMBER

With respect to any benefits payable to a deceased member upon the date of death, or with respect to death benefits payable by virtue of the death of the member where the member's designated beneficiary has predeceased the member and a successor has not been designated, or where the member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered member's:

- Surviving spouse or registered domestic partner; or
- If no surviving spouse or domestic partner, to the covered member's surviving children equally; or
- If no surviving children, to the covered member's estate.

## RIGHT TO APPEAL

The Board of Trustees may change the benefits provided by this Fund. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust Agreement, which established and governs the Fund operations.

All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject only to review by the Board of Trustees. A member or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees at the following address:

Detectives' Endowment Association, Inc.
Health Benefits Fund
26 Thomas Street
New York, New York 10007

The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

# HEALTH PLAN (CONTINUED)

## RIGHT TO RECOUP BENEFIT PAYMENTS MADE IN ERROR OR TO SUSPEND BENEFITS COVERAGE

The Fund has the right to recoup overpayments that were caused by an error in the processing of a claim, or, if additional information comes to the attention of the Fund after the claim has been paid. Furthermore, the Fund has the right to suspend one or more benefits if you have received overpayments or have in any way abused the Fund's benefit program.

If the Fund finds it has overpaid you, or an otherwise ineligible dependent, for a particular benefit, it has the right to recoup the excess amount from you, the member. The Fund may bill you for overpayments made, and/or, it may also reduce future benefit payments to offset the overpaid amounts or it may suspend your benefits until the overpayment is recouped.

## COORDINATION OF BENEFITS

In the event that a person covered by the Detectives' Endowment Association, Inc. Health Benefits Fund is covered under another group plan, there will be "coordination of benefits" regarding reimbursement by this Fund. This coordination will apply in the event that an expense is incurred for a covered item under this Fund that is also covered under the other plan. A determination will be made as to which plan is "primary," or the first plan to pay, and which plan is the "secondary" payer. The method to determine which plan is primary is based on the following rules:

1. If the claimant is a covered member of the Fund, then the Fund will pay benefits first, while a plan covering a member as a dependent will pay second.
2. If a dependent child is covered by plans of both parents, the primary payer will be the member whose birth month and date (excluding year) occurs earlier in the calendar year. The secondary payer will be the member whose birth month and date occurs later in the calendar year. If a plan containing this "Birthday Rule" is coordinated with a plan which contains a gender-based rule, and, as a result the plans do not agree on the order of benefits payment, the gender-based rule plan will determine the order.
3. When parents are divorced or separated, the order of benefit payment for a dependent child is as follows:
    - The plan of the parent with custody pays first.
    - If the parent with custody has remarried the order is as follows:
        - The plan of the parent with custody pays first.
        - Next, the plan of the step-parent pays.
        - The plan of the parent without custody pays last.

    If there is a court decree, which states that one parent is responsible for the child's health care expenses, the plan of that parent will pay first. That court decree will supersede any order stated above.
4. If a person is covered under more than one plan, the plan that he or she is actively employed under pays first, as if there were no other plan. If this Fund is the secondary plan, it will coordinate the benefits with the primary plan so that no greater than 100% of the allowable expense will be paid.

# HEALTH PLAN (CONTINUED)

If you or your family members are eligible to receive benefits under another group plan in addition to this one, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the allowable expenses incurred will be paid jointly by the plans. In order to obtain all of the benefits available, you and your family members should file claims under each plan. Members should file with the primary plan first and then the secondary plan. Be certain to include a copy of the payment voucher (Explanation of Benefits" Form) from the primary plan when filing a claim with the secondary plan.

## COBRA CONTINUATION OF COVERAGE

COBRA continuation coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You or your dependents will be required to pay the necessary premium for the following benefits:

- Dental Benefit Plan
- Optical Benefit Plan
- Hearing Aid Benefit Plan
- Prescription Drug Benefit Plan

COBRA continuation coverage for the Fund is administered by the Fund Administrator at the Fund Office located at 26 Thomas Street New York, New York 10007, telephone **212.587.9120**.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Fund because the following qualifying event occurs:

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Fund because any of the following qualifying events occurs:

- Your spouse dies.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- You become divorced or legally separated from your spouse.

# Health Plan (continued)

Your dependent children will become qualified beneficiaries if they lose coverage under the Fund because any of the following qualifying events occurs:

- The parent employee dies;
- The parent employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund as a "dependent child."

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or death of employee, the employer must notify the Fund Administrator of the qualifying event within 30 days of any of these events.

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), YOU must notify the Fund Administrator. The Fund requires you to notify the Fund Administrator within 60 days after the qualifying event occurs. You must send this notice to the Fund Administrator.** In the event of death, a copy of the death certificate must be provided. In the event of divorce, you must send a copy of the divorce judgement. In the event of legal separation, you must send a copy of the Court Order of Separation.

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, such coverage will begin on the date of the qualifying event or the date that Fund coverage would otherwise have been lost, if later.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment , COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

### 1. Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the Fund Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Fund Administrator is notified of the Social Security Administrator's determination by sending a copy of the determination letter within 60 days of the date of determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Fund Administrator.

# Health Plan (continued)

## 2. Second Qualifying Event Extension of 18-month Period Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies or gets divorced or legally separated while on COBRA. The extension is also available to a dependent child when that child stops being eligible under the Fund as a dependent child while on COBRA. **In all of these cases, you must make sure that the Fund Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Administrator.** In the event of death, a copy of the death certificate must be provided. In the event of divorce, you must send a copy of the divorce judgement. In the event of legal separation, you must send a copy of the Court Order of Separation.

## If You Have Any Questions

If you have any questions about your COBRA continuation coverage, you should contact the Fund Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

## Keep the Fund Informed of Address Changes

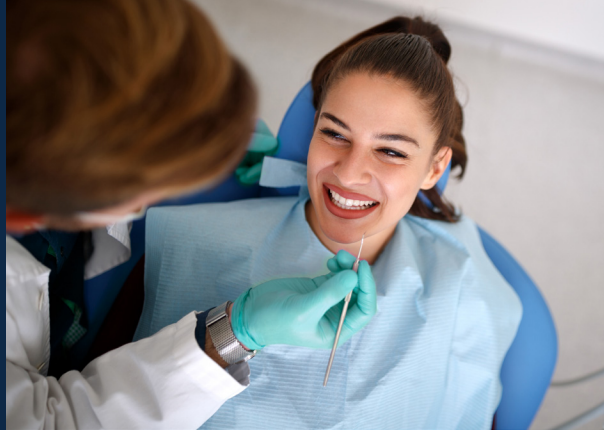
In order to protect your family's rights, you should keep the Fund Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

## Notice of Privacy Practices

A federal law, the Health Insurance Portability and Accountability Act, (HIPAA), requires the Detectives Endowment Association, Inc. Health Benefits Fund (the Fund) to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which was distributed to all current members of the Fund prior to April 14, 2003, and is distributed to all new members upon enrollment, a copy is available from the Fund office.

The Fund will not use or further disclose information that is protected by HIPAA (protected health information), except as necessary for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe the Fund's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

# Dental Plan



## DENTAL BENEFITS

Effective September 1, 2021, Cigna Healthcare ("Cigna") is the new insurance carrier for our comprehensive enhanced dental program for all active and retired members and their covered dependents. Under the enhanced dental program, all active and retired members and their families will be covered by one streamlined plan with both in-network and out-of-network coverage. The Funds' Cigna dental program features many benefit improvements and services, including:

- Access to Cigna's largest participating provider network called the "Total Dental Preferred Provider Organization Network (DPPO)" which has over 150,000 dentists nationwide. By accessing an in-network provider, you will incur lower out-of-pocket expenses. However, if you choose an out-of-network dentist, you will incur higher out-of-pocket expenses, which include any balance that may exceed the "Maximum Allowable Charge" as determined by Cigna.
- An improved schedule of covered dental benefits, including over 450 American Dental Association (ADA) Procedure Codes and higher rates of reimbursement for services provided by out-of-network dentists;
- Unlimited benefits with no annual limits or deductibles (refer to your Certificate of Coverage for specific exclusions and limitations);
- Upgraded orthodontia benefits for adults and children with a lifetime maximum of $4,000;
- Coverage of dental implants;
- 24/7/365 member services through Cigna's customer service team and special toll free 800 number exclusively dedicated to DEA members and their families at **888.735.3715**. When calling, please refer to the DEA Funds Cigna Dental Group number: 3344483
- A special "Micro-site" for DEA members linked to the Funds' website with important information about benefits, customer service, and how to find and select a dentist.
- Access to Cigna Dental Virtual Care, 24 hours per day, seven days per week, 365 days a year. Once you register on the **myCigna.com** website you can log onto "The TeleDentists" website so that you and your covered dependents can receive virtual urgent dental care if needed.

### Who Is Covered?

All covered members and their eligible dependents are entitled to this benefit.

Children from ages 19 to the date of their 23rd birthday (who have proper student verification on file with the DEA) will be eligible. Full-time student verification must be submitted to the DEA Funds Office twice each year for the fall and spring sessions. Please remember to submit student verification prior to the beginning of the fall semester (which covers the time period between September 1 and February 28), and the spring semester (which covers the time period between March 1 and August 31). Student verification forms are available from the DEA Funds Office or are downloadable on line at **www.nycdetectives.org**.

# Dental Plan (continued)

## BENEFIT SUMMARY

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

**Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

| CIGNA DENTAL PPO | | | | |
|---|---|---|---|---|
| Benefit Highlights | In-Network: DEA NETWORK | | Non-Network: See Non-Network Reimbursement | |
| **Reimbursement Levels** | Based on Contracted Fees | | Maximum Allowable Charge | |
| **CALENDAR YEAR BENEFITS MAXIMUM** | | | | |
| **Applies to: Class I, II, III, & IX expenses** | $Unlimited | | $Unlimited | |
| **CALENDAR YEAR DEDUCTIBLE** | | | | |
| **Individual** | $0 | | $0 | |
| **Family** | $0 | | $0 | |
| Benefit Highlights | Plan Pays | You Pay | Plan Pays | You Pay |
| **Class I: Diagnostic & Preventive*** Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain | 100% No Deductible | No Charge | 100% No Deductible | No Charge |
| **Class II: Basic Restorative*** Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation-To include Nitrous Oxide Repairs: bridges, crowns and inlays Repairs: dentures Denture Relines, Rebases and Adjustments Brush Biopsy | 100% No Deductible | No Charge | 100% No Deductible | No Charge |
| **Class III: Major Restorative*** Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures | 100% No Deductible | No Charge | 100% No Deductible | No Charge |

# Dental Plan (continued)

| CIGNA DENTAL PPO | | | | |
|---|---|---|---|---|
| Benefit Highlights | In-Network: DEA NETWORK | | Non-Network: See Non-Network Reimbursement | |
| **Class IV: Orthodontia*** Coverage for Dependent Children and Adults Lifetime Benefits Maximum: $4000 Per Person | 100% No Deductible | No Charge | 100% No Deductible | No Charge |
| **Class IX: Implant*** Lifetime Benefits Maximum: $Unlimited | 100% No Deductible | No Charge | 100% No Deductible | No Charge |
| **BENEFIT PLAN PROVISIONS** | | | | |
| **In-Network Reimbursement** | For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule. | | | |
| **Non-Network Reimbursement** | For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees. | | | |
| **Cross Accumulation** | All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network. | | | |
| **Calendar Year Benefits Maximum** | The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply. | | | |
| **Calendar Year Deductible** | This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply. | | | |
| **Pretreatment Review*** | Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed. | | | |
| **Alternate Benefit Provision** | When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. | | | |
| **Oral Health Integration Program (OHIP)** | Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, and those who qualify are eligible to receive reimbursement of their coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to **www.mycigna.com** or call customer service 24/7 at **888.735.3715.** | | | |
| **Timely Filing** | Out-of-network claims submitted to Cigna after 365 days from date of service will be denied. | | | |

*Covered dental services and benefits must be medically necessary (including appropriateness, health care setting, level of care or effectiveness) as determined by Cigna.

We strongly recommend your provider request a Pretreatment Review from Cigna before costly and major treatment begins. This will provide an estimate of the covered services and costs prior to services being performed.

# Dental Plan (continued)

| CIGNA DENTAL PPO | | |
|---|---|---|
| Benefit Highlights | In-Network: DEA NETWORK | Non-Network: See Non-Network Reimbursement |
| **BENEFIT LIMITATIONS:** | | |
| **Oral Evaluations/Exams** | 2 per calendar year | |
| **X-rays (routine)** | Bitewings: 2 per calendar year | |
| **X-rays (non-routine)** | Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months. | |
| **Diagnostic Casts** | Payable only in conjunction with orthodontic workup. | |
| **Cleanings** | 2 per calendar year including periodontal maintenance procedures following active therapy. | |
| **Fluoride Application** | 2 per calendar year for children under age 19. | |
| **Sealants (per tooth)** | Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14. | |
| **Space Maintainers** | Limited to non-orthodontic treatment for children under age 19. | |
| **Inlays, Crowns,** | Replacement every 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. | |
| **Bridges, Dentures and Partials Denture Relines, Rebases and Adjustments Prosthesis Over Implant** | Reviewed if more than once.<br>Covered if more than 6 months after installation.<br>Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. | |
| **BENEFIT EXCLUSIONS:** | | |

**Covered Expenses will not include, and no payment will be made for the following:**

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Drugs: prescription drugs;
- Charges in excess of the Maximum Allowable Charge

# Dental Plan (continued)

## FREQUENTLY ASKED QUESTIONS

### Q1: Can I go to any dentist?

A1: Yes. You will typically spend less when you visit a Cigna network dentist because Cigna has negotiated discounted rates with these dentists. The DEA Fund's new national dental network is called "Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)". When you use a Total Cigna DPPO (Cigna DPPO Advantage/Cigna DPPO) network dentist you'll save as long as the procedure is listed on the dentist's discount schedule. If you use a non-network dentist, you will not receive Cigna network discounts and the dentist may bill you for the difference between the payment they receive from Cigna and their usual fees.

### Q2: What if my current dentist does not participate in the Cigna Network?

A2: While most in-network dentists currently used by members and their families are part of Cigna's extensive national network, a small number are not. To address this, Cigna has implemented a focused outreach to have these dentists join its network. You may go to **cigna.com** to see if your dentist is participating, or you may call Cigna's dedicated toll free member number at **888.735.3715**.

### Q3: How are non-network dentists reimbursed under the new Cigna plan?

A3: Non-network dentists are reimbursed based on a Maximum Allowable Charge (MAC) schedule. Cigna will reimburse covered services at 100% of the Maximum Allowable Charge. There will be no charge to you if the non-network dentist accepts Cigna's paid amount as payment in full. However, non-network dentists may balance bill you for the difference between Cigna's payment and their usual fee. A quick example of how in-network vs non-network dentists are reimbursed is as follows;

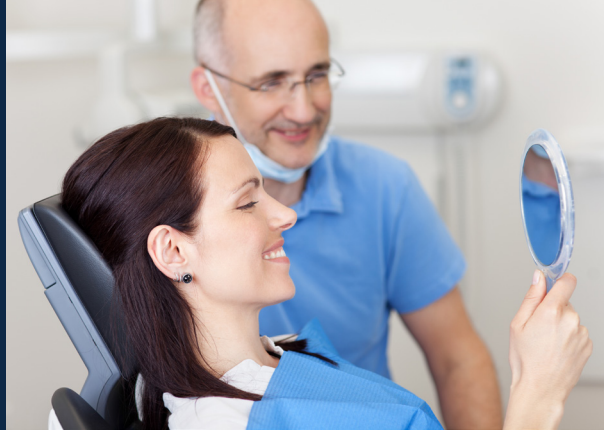
| PROCEDURE: CROWN – PERMANENT CAST & PORCELAIN | | |
|---|---|---|
| | In-Network Dentist | Non-Network Dentist |
| **Benefit:** | 100% of the Discounted Fee | 100% of the Maximum Allowable Charge (MAC) |
| **Charged Amount:** | $650 (discounted fee) | $1,000 (dentist's usual fee) |
| **Cigna Pays:** | $650 | $650 (MAC scheduled amount) |
| **You Pay:** | $0 | $350 (difference between dentist usual fee & MAC)* |

*you will have no charge if dentist accepts Cigna's MAC payment

### Q4: Do I choose a dentist when I sign up for the plan?

A4: No, you are free to see any network or non-network dentist (general dentist or specialist) without notifying Cigna in advance. You can find a network dentist or specialist online at Cigna.com before you sign up, or go to your personalized website at **myCigna.com** after you sign up. You can also call Cigna's 24/7/365 dedicated toll free number at **888.735.3715**, and we will help you find a network dentist in your area.

# Dental Plan (continued)



**Q5: Do I pay up front and submit a claim or will the dentist submit claims for me?**
A5: In most instances, if you are using an in-network dentist, they will submit claims on your behalf. Cigna accepts electronic claims from non-network dentists, however a non-network dentist may require you to file your own claims after payment if they choose not to file on your behalf.

**Q6: Can I download my ID card to my device?**
A6: Yes. You will be receiving ID cards in the mail; however, once you are registered on the myCigna.com Home page you will see "ID Cards." The "ID Cards" icon is usually on the bottom left of a smart phone and top right on a computer.

**Q7: What if it's 3:00am and I urgently need dental care?**
A7: Virtual dental care is available 24/7/365. You must first log onto myCigna.com to have access to our virtual dental care. Once you are in myCigna.com follow the prompts to the virtual care portal. This will take you to "TheTeleDentists" website where you will need to create an account. Afterwards, you will be able to receive virtual urgent dental care. Please note that the dentist must be able to see you from your device.

**Q8: What are my in-network copays/deductibles/coinsurance?**
A8: None. You have no copays, deductibles, or coinsurance for in-network coverage. You may have some out-of-pocket costs if you utilize an out-of-network dental provider.

**Q9: What is my calendar year maximum allowed benefit?**
A9: The only maximum allowed benefit is for orthodontia, which is a $4,000 lifetime maximum per person. All other benefits are unlimited, subject to applicable plan frequency limits, exclusions and medical necessity provisions.

**Q10: Do I need a referral to see a dental specialist?**
A10: No. However we do suggest seeing an in-network dentist, if possible, to save money.

**Q11: What do I have to do for enrollment?**
A11: Nothing. Enrollment will be facilitated between the DEA Funds and Cigna. However, please notify the DEA Funds office immediately if you have any change in family status (e.g. marriage, divorce, birth, adoption, etc.) that affects your enrollment status.

**Q12: Who can I call prior to the 9/1/2022 effective date if I have questions?**
A12: Cigna has created a dedicated 24/7/365 toll free number that members can call at any time prior to enrollment. The number is: **888.735.3715**. You can also call the DEA Funds office at **212.587.9120** during normal business hours.

# Dental Plan (continued)

Q13: Are there any differences in the dental benefits for Active members and Retirees?
A13: No. Both Active members and Retirees have the same exact benefits and the same Cigna dental network.

Q14: How many dentists are in the Cigna network?
A14: Cigna has over 150,000 dentists in their Total Cigna DPPO (Cigna Advantage DPPO/Cigna DPPO) network.

Q15: To what age are dependent children covered?
A15: Children are covered until age 19, and full-time students are covered until age 23.

Q16: Is orthodontia coverage available to eligible children and adults?
A16: Yes. Orthodontia coverage for adults is an enhanced coverage that has been added effective 9/1/2022.

Q17: Will I have to give my Social Security number in order to enroll with Cigna?
A17: No. Members will be issued a unique ID number instead of a social security number. Your new Cigna Dental unique ID number will look like **D32xxxxxx** (the last 6 digits will be the same as your dental DEA ID number today).

Q18: What is Transition of Care (TOC), and how does Transition of Care work with Cigna?
A18: Transition of Care (TOC) allows covered members and their family to continue to receive services for specific procedures during coverage transitions. A TOC service is a dental procedure that begins while you're covered under one insurance carrier or plan and is finished while you're covered under a different insurance carrier or plan. Typically, TOC services require more than one trip to the dental office for completion. TOC applies to orthodontic treatment and some general dentistry services, such as root canal therapy, crowns, partials or bridges. Please note that if you are in active treatment for the following:

Orthodontia - Benefits for active treatment of orthodontic services will be covered under the new Cigna insurance policy effective 9/1/2021. Please be sure to let your provider know about the change in carrier so they can submit claims directly to Cigna for payment.

Other Covered Dental Services - Benefits for dental services rendered prior to 9/1/2021 are the responsibility of the DEA Funds' current dental plan administrator/insurance carrier, Healthplex. If a claim is denied for services rendered prior to 9/1/2021 or for TOC dental services, please contact the DEA Funds office and they will work with Healthplex and/or Cigna to have the claim reviewed.

# Prescription Plan

## PRESCRIPTION DRUG BENEFITS

The Detectives' Endowment Association Health Benefits Fund provides a prescription drug plan to its members and their eligible dependents, which is administered by a prescription benefit manager (PBM).

### Who Is Covered?

All covered members and their eligible dependents up to age 26 are entitled to this benefit.

### What is the Benefit

The Fund only covers prescription drugs prescribed by a doctor, dentist, or osteopathic physician and dispensed under an Rx number by a licensed pharmacist.

The Fund covers maintenance prescription drugs (such as birth control pills covered under PPACA, blood pressure or cholesterol medications, etc.) dispensed by your local pharmacy, or you may use the mail order supply service for maintenance prescription drugs.

### How To Fill a Prescription

#### Participating Pharmacy

Covered members and eligible dependents may fill prescriptions at participating pharmacies (up to a 30-day supply) for which the following copayments will be incurred:

**For drug spend up to $10,000 per calendar year per family unit:**

| | |
|---|---|
| **Generic** | $0 |
| Formulary (Preferred) Brands | 25% of the cost of the prescription |
| Formulary (Non-preferred) Brands | 50% PLUS the cost of difference between the brand and generics |
| Multi-Source Brands | 25% PLUS the cost difference between the brand and generics |
| Multi-Source (Non-preferred) Brands | 50% PLUS the cost of difference between the brand and generics |

For drug spend over $10,000 per calendar year per family unit: 50% for all medications. There is a mandatory generic plan associated with this program, so in addition to the copayments, members are responsible to pay the cost difference between the brand name drug and its generic equivalent, when one is available.

To locate a participating pharmacy, please contact BeneCard Services at **888.DEA.NYPD (1.888.332.6973)**, or visit their website at **www.benecardpbf.com**. If you would like a particular pharmacy to participate in the network, please call BeneCard PBF number listed above.

# Prescription Plan (continued)

## Mail-Order Pharmacy

Covered members and eligible dependents may fill prescriptions up to a 90 day supply through the mail order pharmacy for which the following copayments will be incurred:

**For drug spend up to $10,000 per calendar year per family unit:**

| | |
|---|---|
| **Generic** | $0 |
| Formulary (Preferred) Brands | 25% of the cost of the prescription |
| Formulary (Non-Preferred) Brands | 50% of the cost of the prescription |
| Multi-Source Brands | 25% PLUS the cost difference between the brand and generics |
| Multi-Source (Non-preferred) Brands | 50% PLUS the cost of difference between the brand and generics |

Please note that using the mail order option may help your prescription drug dollars go further because the mail order pharmacy's prices for generic and brand name drugs are usually significantly lower than the prices charged by local pharmacies.

## How Do I Obtain the Benefit?

### Participating Pharmacy

Present your Detectives' Endowment Association Health Benefits Fund drug card to the pharmacist with your prescription and pay the applicable copayment. If you do not have your drug card, provide your identification number, the name of the Fund and the name of the Fund's prescription benefit manager (BeneCard PBF) to the pharmacist.

### Nonparticipating Pharmacy

If you use a nonparticipating pharmacy, you must pay for your prescription at the time it is filled. To receive reimbursement, you must complete a claim form and return it to **www.benecardpbf.com**. Also, you may print a copy of the claim form off of BeneCard PBF's website at **www.benecardpbf.com** (identified in your drug brochure) with an original receipt for the item claimed. Please include the name of the prescription drug you are requesting reimbursement for on the claim form. You are responsible for the applicable copayment.

Prescription drug claim forms can be obtained from the Fund office or from the DEA website at **www.nycdetectives.org**.

# Prescription Plan (continued)

## Mail Order Pharmacy

Enclose both the original prescription and the applicable copayment (personal check or credit card information) for each prescription or refill and mail service order form to Benecard Central Fill, P.O. Box 779, Mechanicsburg, PA 17055-0779 with your name, identification number and the address to which you want the prescription(s) shipped. There is no limit to the number of prescriptions that can be included in one envelope. Prescriptions are filled immediately; however, you must allow for delivery time both ways. Your medication will be delivered within ten to fourteen (10-14) business days from the day you mail your prescription to BeneCard PBF.

## Out-of-Pocket Maximum

Your out-of-pocket spending on benefits may not exceed $8,700 for single coverage and $17,400 for family coverage. The limit per individual with family coverage will be $8,700 per individual per calendar year. The out-of-pocket maximum includes your deductibles, coinsurance and copayments. After you meet the out-of-pocket maximum, your copayment or coinsurance will be $0 for the remainder of the calendar year.

## Specialty Medications

All specialty drugs and the following drugs are excluded from coverage:
ZenPep, Creon, Pancreaze, Pertzye, Ultresca, Viokace, Actiq, Rayos, Subsys, Abstral, Fentora, Lazanda

Members using specialty drugs or those listed above prior to June 19, 2014 will be grandfathered for those medications only. If the drug therapy is changed but treats the same disease state, the new drug will not covered.

Please visit **www.benecardpbf.com** or **www.nycdetectives.org** for a list of specialty drugs and a list of copay assistance programs or contact BeneCard PBF at **1.888.DEA.NYPD** or **1.888.332.6973**.

## Psychotropic and Asthma Drugs

Prior to July 1, 2005, Psychotropic and Asthma drugs were covered by the "PICA" (Psychotropic Injectable, Chemotherapy and Asthma) Drug Program for all covered members who elect a City-provided health plan.

Injectable and Chemotherapy drugs remain covered by PICA, however, effective July 1, 2005, Psychotropic and Asthma drugs are covered by the Detectives' Endowment Association Health Benefits Fund.

Covered members and eligible dependents may fill prescriptions at participating pharmacies or through the Fund's mail order pharmacy program, for which the following copayments will apply:

| | |
|---|---|
| **Generic Medications** | $0 |
| Formulary (Preferred) Brands | 45% of the cost of the prescription |
| Multi-Source Brands | 45% PLUS the cost difference between the brand and generics |

## Step Therapy

When second line drugs are inappropriately utilized before first line drugs, which may have the same indication, the cost to members, as well as the Fund is greater than necessary.

# Prescription Plan (continued)

## Preventive Medications

Effective 7.1.17, the following medications and products (subject to specific age limits) are covered at $0 copayment under the medical benefit plan provided by GHI/Emblem Health . A valid prescription from your physician is required. It is important that you show your GHI Medical ID card to the pharmacist to obtain these medications/products.

| CATEGORY | AGE LIMITS |
|---|---|
| **Generic Contraceptives** | ≥ 10 years |
| **Aspirin for Men** | 45–79 years |
| **Aspirin for Women** | 55–79 years |
| **Folic Acid Supplements** | 10–55 years |
| **Iron Supplements for Infants** | 6–12 months |
| **Gonorrhea (Newborn Eye Drops)** | 0–7 days |
| **Fluoride Chemoprevention Supplements** | 7 months – 6 years |
| **Vitamin D Supplements** | ≥ 65 years |
| **Breast Cancer Risk-Reducing Medications such as Tamoxifen, Raloxifin** | Not specified |

## Exclusions

Under the Fund's prescription drug plan, benefits will not be paid for the following:

- Drugs that may be legally purchased without a prescription, even if prescribed in writing and dispensed under an Rx number, unless otherwise noted under preventive medications.
- Antigens, allergens, or other prescription drugs that are purchased from a laboratory or a physician; only prescription drugs (including antigens or allergens) that are prescribed by a physician and dispensed by a licensed pharmacist under an Rx number are covered.
- Drugs of an experimental nature that have not been approved by the Food and Drug Administration.
- Prescription drugs for which coverage is provided by the member's basic health plan.
- Drugs which are not considered medically necessary for the care and treatment of an injury or sickness.
- Drugs which are considered "off-label use" as they are not prescribed in accordance with FDA-approved utilization or are prescribed or dispensed in a manner contrary to normal medical practices.

# Prescription Plan (continued)

- Drugs for which the cost is recoverable under a governmental program, Workers' Compensation, occupational disease law, or medication, for which no charge is made to you.
- Immunologicals, vaccines, allergy sera, biological sera, blood plasma, and charges for the administration or injection of medications.

All Specialty drugs and the following drugs:

- ZenPep, Creon, Pancreaze, Pertzye, Ultresca, Viokace, Actiq, Rayos, Subsys, Abstral, Fentora, Lazanda

### Therapeutic Categories of Drugs Excluded from Coverage Include:

- Drugs prescribed for cosmetic purposes
- Hair loss medications
- Weight control
- Infertility treatment
- Smoking cessation or deterrence
- Needles, syringes and injection devices
- Insulin and oral diabetic medications
- Self-administered injectable medications, such as injectable forms of fertility and contraceptives, Imitrex, etc., except where otherwise noted under PICA.
- Erectile dysfunction drugs

# Optical Plan

## OPTICAL BENEFITS

The Detectives' Endowment Association Health Benefits Fund provides a comprehensive vision care plan to its members and their eligible dependents through a network of licensed optical providers, administered by Davis Vision, Inc.

Members and their covered dependents shall be entitled to an eye examination and the choice of spectacle lenses or contact lenses (in lieu of eyeglasses) on an annual basis from the last date of services (rolling 12-month calendar). A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied by Davis Vision.

### Who Is Covered?

All covered members and their eligible dependents are entitled to this benefit.

Children from ages 19 to the date of their 23rd birthday (who have proper student verification on file with the DEA) will be eligible. Full-time student verification must be submitted to the DEA Funds Office twice each year for the fall and spring sessions. Please remember to submit student verification prior to the beginning of the fall semester (which covers the time period between September 1 and February 28), and the spring semester (which covers the time period between March 1 and August 31). Student verification forms are available from the DEA Funds Office or are downloadable on line at **www.nycdetectives.org**.

### How To Receive Services

- Call the network provider of your choice and schedule an appointment. Members can call **800.999.5431** to access the Interactive Voice Response Unit (IVR), to obtain the names and addresses of nearby network providers. Members may also go to **www.davisvision.com** and utilize the "Find a Doctor" feature.
- Identify yourself as a Davis Vision plan participant and a Detectives' Endowment Association Health Benefits Fund member or covered dependent.
- Provide the office with the member's identification number and the name and date of birth of any covered dependent needing services.
- The provider's office will verify your or your covered dependent's eligibility for services.
- No claim forms or identification cards are required.

| SCHEDULE OF COVERED OPTICAL BENEFITS | |
|---|---|
| **Service** | **In Network Copayment** |
| Eye Examination | $0* |
| **Frames** | |
| Pair 1 | $0 for Fashion, Designer, or Premier selection frames |
| Pairs 2 & 3 | $65 for Designer selection frames and spectacle lenses |
| | $90 for Premier selection frames and spectacle lenses |

*Outside of NY:$42.00 copayment

# Optical Plan (continued)

| Spectacle Lenses | In Network Copayment | |
|---|---|---|
| **Single Vision** | $0 | |
| **Bifocal** | $0 | |
| **Trifocal** | $0 | |
| **Oversize** | $0 | |
| **Contact Lenses** | **In Network Copayment** | |
| **Standard, soft daily wear** | $0 | |
| **Disposable/planned replacements** | $0 for 8 boxes disposable or 2 boxes planned replacement | |
| **Special Type Contact Lenses** | $60 allowance | |
| **Optional Services** | **Pair 1** | **Pair 2&3** |
| **Polycarbonate lenses (adults)** | $30* | $30* |
| **Scratch-resistant coating (single vision)** | $0 | $15 |
| **Scratch-resistant coating (multi vision)** | $0 | $20 |
| **Photosensitive lenses (single vision)** | $0 | $10 |
| **Photosensitive lenses (multifocal)** | $0 | $20 |
| **Ultraviolet coating** | $0 | $10 |
| **Anti-reflective coating (standard)** | $33 | $33 |
| **Anti-reflective coating (premium)** | $48 | $48 |
| **Polarized lenses** | $60 | $60 |
| **Intermediate vision lenses** | $0 | $30 |
| **Blended invisible bifocals** | $0 | $10 |
| **Plastic photosensitive lenses** | $65 | $65 |
| **High-index lenses** | $55 | $55 |
| **Progressive lenses (standard)** | $50 | $50 |
| **Progressive lenses (premium)** | $80 | $80 |

*covered in full for dependent children or monocular patients

## Exclusions

The following items are not covered by the Fund's vision program:

- Medical treatment of eye disease or injury;
- Vision therapy;
- Special lens designs or coatings, other than those previously described;
- Replacement of lost eyewear;
- Nonprescription (plano) lenses;
- Services not preformed by licensed personnel.

# Hearing Aid Plan

## HEARING AID BENEFIT

The Detectives' Endowment Association Health Benefits Fund provides a hearing aid benefit to its members and their eligible dependents.

### Who Is Covered

All covered members and their eligible dependents are entitled to this benefit.

### What Is the Benefit?

The Fund provides you and your spouse with a reimbursement of up to a maximum of $500 per ear towards the purchase of a physician-prescribed hearing aid, once every four (4) years and your eligible dependent children once every two (2) years.

### Exclusions

The Fund will not pay benefits for the following:

- Hearing examinations;
- The purchase of batteries;
- Repair;
- Ear molds; and
- Service contracts.

### How Do I Obtain the Benefit?

1. Telephone or write to the Fund office to obtain a Hearing Aid Benefit Claim Form.
2. Have the hearing aid appliance dealer complete the appropriate portion of the claim form (or you may attach the original bill or receipt indicating the service rendered and the cost). You must indicate whether the claim is for the right ear, the left ear or both ears.
3. Complete your portion of the claim form and mail it to the Fund office with a physician's prescription for the hearing aid.

### Northwell Body Scan Program

# Equipment & Nursing Plan

## DURABLE MEDICAL EQUIPMENT AND PRIVATE DUTY NURSING BENEFITS

### Rider to HIP HMO Contract

The Detectives' Endowment Association Health Benefits Fund provides a Rider to its members and their eligible dependents enrolled in the City's HIP plan, which provides durable medical equipment and private duty nursing benefits.

### Who Is Covered

All covered members and their eligible dependents who participate in the City's HIP plan.

### What Are the Benefits?

#### Private Duty Nursing

***Covered Services***

Private Duty Nursing care will be provided during a hospital admission. Private Duty Nursing must be skilled care and must be provided by a graduate nurse or a licensed practical nurse who is not a relative of or resides with the Member. Nurse's Aide services are not covered, regardless of why a nurse's aide was used, even if ordered by a Physician.

***Benefit Limitations***

No benefits will be provided for the first 72 hours of private duty nursing care. After the first 72 hours, the Rider will pay for the usual and customary charges, for any additional hours of private duty nursing care ordered by the member's attending physician.

All other terms, conditions, limitations and exclusions of the HIP group contract apply to the benefits provided by the Rider.

#### Durable Medical Equipment

***Definitions***

A "Covered Appliance" is one of the following items, which is prescribed by a physician, dispensed by a participating provider and approved by HIP. HIP maintains a list of covered appliances that contains items in each of the categories listed below. This list is prepared by HIP and is periodically reviewed and modified. HIP will determine whether a covered appliance should be customized, rented, purchased, or repaired.

# Equipment & Nursing Plan (continued)

1. Durable Medical Equipment is:
    a. Primarily and customarily used to serve a medical purpose;
    b. Generally not useful to a person in the absence of illness or injury;
    c. Appropriate for use in the home;
    d. Medically necessary for the care and treatment of the Member's illness or injury.
2. Prosthetic devices which replace all or part of an internal body organ or external limb. Eyeglasses, hearing aids and dental prosthetics, including dentures, are not covered. However, dental prosthetics needed due to accidental injury to sound, natural teeth, will be covered.
3. Orthopedic devices which are required for the treatment of injuries or disorders of the skeletal system and associated muscles, joints and ligaments. Corrective or orthopedic shoes are not covered, unless HIP determines that the member's condition requires a corrective shoe that can only be made from a mold or cast of his or her foot.

A "deductible" is a charge, which the member is required to pay out-of-pocket for items covered under the Rider. The Member is responsible for payment of the deductible directly to the participating provider. The deductible is applicable to each member covered under the contract and will not count toward any maximum out-of-pocket expenses under the contract.

***Benefits***

Members must obtain all Covered Appliances from a Participating Provider. Covered Appliances are subject to a $0 annual deductible.

All other terms, conditions, exclusion and limitations of the HIP group contract apply to the benefits provided by the Rider.

# Body Scan Plan

## FULL BODY SCAN DISCOUNT BENEFIT

The Detectives' Endowment Association Health Benefits Fund provides a Full-Body Scan Discount Benefit.

### Who Is Covered

All covered members only.

### What Is the Benefit

The Full Body Scan Discount Benefit provides one (1) confidential full body scan screening (four radiological tests of the heart, lungs, abdomen and pelvis) per member per lifetime through Inner Imaging, P.C. for a discounted fee of $375, $200 of which will be billed to and paid by the Fund with the balance of $175 to be paid directly to Inner Imaging, P.C. at the time of service by the member.

Your eligible dependents may receive one (1) full body screening per lifetime through Inner Imaging, P.C. for the same discounted fee of $375, which must be paid for in its entirety by you or your eligible dependents. The Fund will not pay any portion of this fee for your eligible dependents.

### How Do I Obtain the Benefit

Contact Inner Imaging directly at **212.777.8900** to schedule an appointment for a full body scan screening. Then, contact the Fund office to obtain a voucher. Inner Imaging will bill the Fund $200 of the $375 discounted fee and you pay the $175 balance at the time of service.

# Northwell Body Scan Program

## Northwell Body Scan Program

### New Health Screening Body Scan Program: Effective 11/1/2021 (Being offered as a one-year pilot program)

Northwell Direct offers the latest technology for diagnostic body scan screenings to the Detectives' Endowment Association Health Benefits Fund & Detectives' Endowment Association Retiree Health Benefits Fund. A body scan screening for various signs of heart disease is of particular importance because these conditions are responsible for hundreds of thousands of preventable deaths every year in the U.S. At Northwell Health Staten Island University Hospital, a single body scan, from the chin to the upper abdomen, can not only identify signs of heart disease, but also yield important information regarding the health of your lungs, liver, pancreas, and additional structures in the upper abdomen/body.

### Member Body Scan Screening Experience:

- Member must call the dedicated call line at **516.492.3297** to initiate process and provide any additional information that may be required.
- Northwell Health will contact the member to make an appointment
- Member receives screening result via call and mail, Member's PCP can receive results upon request.
- Care coordination and navigation support available through **888.321.DOCS.**

### Clinical Benefits:

Body scan screenings help identify those at risk before any symptoms become evident. The body scan takes several minutes, and special techniques minimize the amount of radiation exposure. Northwell radiologists review the scan to detect abnormalities that may indicate the presence of cancer in its earliest and most treatable stages.

### Special Price for Body Scan: $375

- - Benefit payable by the DEA Health Benefits Fund or DEA Retiree Health Benefits Fund: $200
- - Member payment required at point of service: $175

### Service Location:

**Verrazano Imaging at Staten Island University Hospital**

256A Mason Ave, Staten Island, NY 10305

For further information, call the DEA Health Benefits Funds at **212-587-9120.**

# SUPPLEMENTAL INSURANCE

## OPTIONAL AND AT THE MEMBERS' EXPENSE

The DEA has entered into an agreement with Aflac New York to offer supplemental coverage to all DEA members for an Accident Policy, Cancer Protection Policy, Dental Supplement, and/or Hospital Protection Policy.

Do not mail applications to the Aflac Albany address. If you need further information or are interested in enrolling, contact the following Aflac New York Agents:

Stephen DeMaria
Cell 917.848.8334
Office 212.679.9807
Toll Free 800.564.2775

Joseph Pernice
917.886.7215
Fax 212.658.9662

Aflac policies are purchased via payroll deduction. Please refer to the DEA website at **www.nycdetectives.org** for the latest premiums for Aflac coverage.

Aflac has the finest Specified Disease Cancer Protection policy, one that pays cash benefits directly to policyholders. The rates are the same for all active members. Policies are portable and can be carried with you at retirement at the same group rates with no increase. We highly recommend you consider this policy.

# Counseling

**Counseling:**

- The DEA provides members with counseling on Pension, Disability, Retirement and Grievance matters.
- For inquiries please contact the DEA's Financial Secretary Ken Sparks at our Executive Offices at **212.587.1000**.

*This benefit summary prepared by*

Gallagher

Insurance | Risk Management | Consulting

January 2022