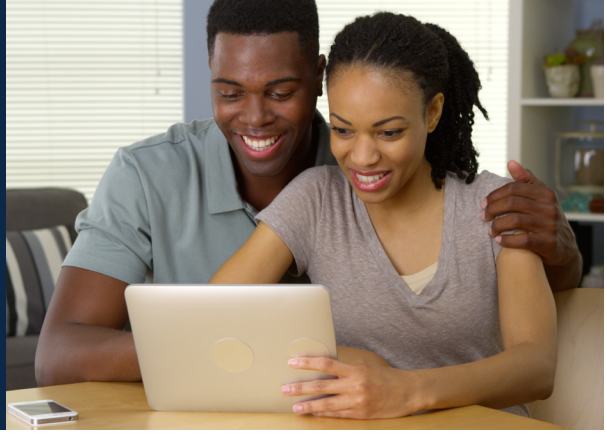
Detectives' Endowment Association, Inc.
Police Department, City of New York

Health Benefits Fund

Comprehensive Benefits Booklet

Retiree 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

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.

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
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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
- Catastrophic
- Equipment and Nursing
- Body Scan

Health Plan

HEALTH PLAN ELIGIBILITY

WHO IS ELIGIBLE FOR COVERAGE UNDER THE NYPD HEALTH PLAN?

Eligible Members

All Retired Detectives and Detective Investigators for whom the Detectives' Endowment Association, Inc. Retirees' Health Benefits Fund ("Fund") receives a contribution under Collective Bargaining Agreements with the City of New York are eligible for these benefits.

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 of 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 partner 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.

Health Plan (continued)

- ***Your unmarried dependent children (including legally adopted children)*** up until their 19th birthday. Unmarried dependent children over age 19 but less than age 23 are also eligible for Fund benefits, provided that they are chiefly dependent upon you, the member, for support and maintenance, they permanently reside with the member **and** are full-time students in an accredited educational institution. Proof of attendance at an educational institution must be submitted twice a year (fall and spring) for a child between the ages of 19 and 23.

- ***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 stepchild 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 19 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 19). 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 your domestic partner in your City health plan or a Domestic Partner Registration Certificate or Civil Union Certificate from an applicable jurisdiction;
5. Legal Adoption papers;
6. Legal Guardianship papers;
7. For physically or mentally disabled, dependent children age 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.

Important Notice

Effective July 1, 2011 the new health care reform law, the Affordable Care Act, requires group health plans that provide dependent coverage for children to continue to make such coverage available to an adult child until the child turns 26 years of age. The Health Plan will comply with this mandate covering dependent children to age 26 and full-time student status will no longer be a requirement effective July 1, 2011. However, coverage will not be extended to dependent children who have access to other employer-sponsored health coverage, as stipulated by the health care reform law.

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
- To take all reasonable steps to affect 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.

Health Plan (continued)

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/registered domestic partner;
- If no surviving spouse/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.
Retirees' 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. Retirees' 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 benefits of the plan which covers the child of the parent whose date of birth (month and day only, excluding year) occurs earlier in the calendar year, will be determined to be the primary payer. The benefits of the plan which covers the child of the parent whose date of birth (excluding the year) occurs later in the calendar year, will be determined the secondary payer. 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:

    - The plan of the parent with custody pays first and the plan of the parent without custody pays second.
    - If the parent with custody has remarried the order is:
        - 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.

Health Plan (continued)

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 supercede 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.

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.

OPT-OUT OPPORTUNITY - DENTAL AND OPTICAL BENEFITS

Federal law requires that the Fund provide an opportunity for members to "opt-out" of coverage for their dental and optical benefits offered by the Fund. Once you and/or your eligible dependents are duly enrolled for benefits from the Fund, you will continue to be covered unless you "opt-out" of coverage, in writing, to the Fund. If you wish to continue your eligibility for dental and optical benefits, which will continue uninterrupted, you need to do nothing.

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
- Supplemental Medical Rider 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**.

Health Plan (continued)

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

- 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.

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 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:

Health Plan (continued)

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.

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. Retirees' 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 of which 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)

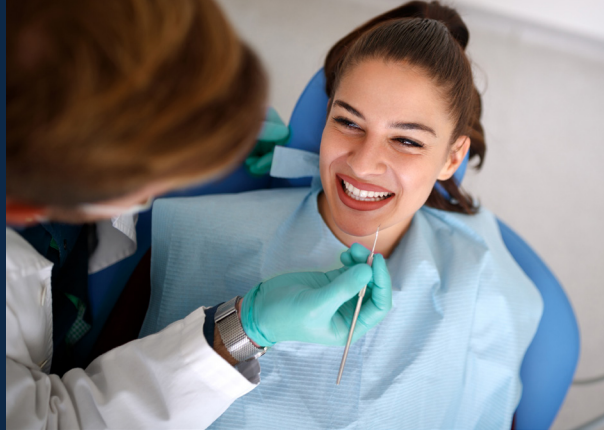
BENEFIT SUMMARY

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. Covered if more than 6 months after installation. 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 if I have questions?
A12: Cigna has created a dedicated 24/7/365 toll free number that members can call at any time. 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 9/1/2021.

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 Retirees' Health Benefits Fund provides a prescription drug plan to its members and their eligible dependents, which is administered by a prescription benefit facilitator ("PBF").

Who Is Covered?

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

Children from the ages of 19 to the date of their 23rd birthday (who have proper student verification on file with the DEA) will be eligible to use the Benecard PBF card to obtain their prescriptions, and simply pay the copayment or coinsurance. 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**.

What Is the Benefit?

Effective July 1, 2015, the DEA is increasing the annual plan maximum from $11,000 to $15,000. This plan maximum is calculated from July 1st through June 30th each year. The deductibles for the plan are $50 for individual and $150 for family.

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 (when medically necessary), 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

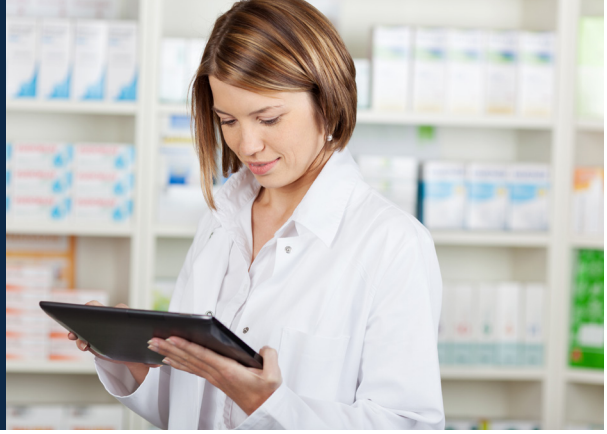
Participating Pharmacy

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:

Generic	$10 or less (not to exceed the cost of the medication)
Formulary (Preferred) Brands	The greater of $10 or 30%
Multi-Source Brands	The greater of $10 or 30% PLUS the cost difference between the brand and generic

To locate a participating pharmacy, please contact Benecard PBF at **888 DEA NYPD.(888.332.6973)**, or visit their website at **www.BeneCardpbf.com**.

Prescription Plan (continued)



Mail-Order Pharmacy

Covered members and eligible dependents may fill prescriptions through the mail-order pharmacy for which the following copayments will be incurred:

Generic	The greater of $10 or 30%
Formulary (Preferred) Brands	The greater of $10 or 30%
Multi-Source Brands	The greater of $10 or 30% PLUS the cost difference between the brand and generic

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. The maintenance (continuous medication) prescription drug program entitles you to a three (3) month supply with applicable copays or coinsurance.

How Do I Obtain the Benefit?

Participating Pharmacy

Present your Detectives' Endowment Association Retirees' 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 facilitator, Benecard PBF, to the pharmacist.

Nonparticipating Pharmacy

If you use a non-participating 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 Benecard PBF 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 or coinsurance.

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

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 it to Benecard Central Fill, PO 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 Central Fill.

Prescription Plan (continued)

Specialty Medications

All specialty medications will be dispensed through Benecard Central Fill, BeneCard PBF's mail order facility. One initial fill through a retail pharmacy is permitted. The copayment is the greater of $10 or 30% for a 30-day supply

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, as of July 1, 2005, Psychotropic and Asthma drugs have been covered by the Detectives' Endowment Association Health Benefits Fund following a change in the Municipal Labor Committee collectively bargained agreement with the City of New York's labor unions.

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:

Asthma and Psychotropic Medications	Greater of $10 or 45%

Step Therapy Program"

A mandatory Step Therapy program will be implemented beginning on July 1, 2015. The Step Therapy program requires members to use a lower-cost medication prior to using the "second-line" or higher cost medication within the same category. The list of categories requiring step therapy is developed by doctors, pharmacists and experienced medical personnel. A sample of these classes includes proton pump inhibitors, sedative hypnotics, rheumatoid arthritis, and psoriasis medications.

How a Step Therapy program works:

When a prescription is submitted to the pharmacy for a medication requiring Step Therapy, the claim will reject if the 'first line' medication has not been tried. The pharmacist will advise the member to consult their prescribing physician or will contact the prescribing physician directly to see if the 'first line' medication is acceptable. Once approved, the prescribing physician will submit a new prescription to the pharmacist so the medication can be dispensed. If the prescribing physician believes the originally prescribed medication is medically necessary to treat the member's medical condition, the physician, pharmacist or member can contact the BeneCard PBF clinical team at **888.DEA.NYPD (888.332.6973)** and request a review of the medication therapy.

How do I know if my medication is on the Step Therapy list?

A list of the therapeutic categories and medications requiring Step Therapy is included on Page 20

Current utilizers will be grandfathered using a 6 month look-back period for both BeneCard PBF's Standard Drug List and BeneCard PBF's Specialty List.

Prescription Plan (continued)

Step Therapy Program

Therapeutic Class	Medical Condition	1st Line Medications	2nd Line Medications
Proton Pump Inhibitors	Ulcer/GERD	Omeprazole, lansoprazole, omeprazole/sodium bicarbonate, pantoprazole, NEXIUM, Rabeprazole	ACIPHEX, DEXILANT, PREVACID (MS), PREVACID SOLUTABS, PRILOSEC RX ORAL SUSPENSION, PROTONIX, ZEGERID
Intranasal Steroids	Allergy	Flunisolide, Fluticasone Propionate Nasal Spray, NASONEX, QNASL	Single-source brands (i.e. BECONASE AQ, NASACORT/AQ, RHINOCORT AQUA, VERAMYST, OMNARIS), FLONASE, NASALIDE, NASEREL, ZETONNA, DYMISTA
ARBs	Hypertension	Candesartan, candesartan/hctz, losartan/ losartan HCTZ, irbesartan/irebesartan/ hctz, telmisartan, telmisartan/HCTZ, telmisartan/amlodipine valsartan, valsartan/hctz, eprosartan	ATACAND/ATACAND HCT, BENICAR/ BENICAR HCT, AVAPRO, AVALIDE, TEVETEN/HCT, COZAAR, HYZAAR DIOVAN/ DIOVAN HCT, EDARBI, EDARBYCLOR, MICARDIS/MICARDIS HCT, TWYNSTA
SSRI	Mental health	Citalopram, Fluvoxamine, Fluoxetine, Paroxetine, Sertraline, Escitalopram	LEXAPRO, LUVOX CR, PEXEVA, CELEXA, PROZAC, PAXIL, PAXIL CR, ZOLOFT
Bisphosphonates	Osteoporosis	Alendronate, ibandronate, Pamidronate, etidronate, zoledronic acid	ACTONEL, ACTONEL W/ CA, FOSAMAX,ATELVIA, FOSAMAX D, BONIVA, SKELID, ZOMETA, RECLAST, AREDIA, DIDRONEL, BINOSTO
Triptans	Migraines	Sumatriptan, Naratriptan RELPAX, rizatriptan, zolmitriptan	AMERGE, FROVA, ZOMIG/ZMT, TREXIMET, AXERT, MAXALT/MLT SUMAVEL, IMITREX, ALSUMA
Sleep Aids	Insomnia	Generics: Zolpidem, Zaleplon	AMBIEN CR, EDLUAR, LUNESTA, ROZEREM, AMBIEN , SONATA, ZOLPIMIST, INTERMEZZO

Please note: The medications listed above are subject to change.

All questions and requests for additional information should be directed to BeneCard PBF Member Services at **888.DEA.NYPD (888.332.6973)** or the DEA Funds Benefits office at **212.587.9120**.

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.
- 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.

Prescription Plan (continued)

Notice of Creditable Coverage

THE DETECTIVES' ENDOWMENT ASSOCIATION RETIREES' HEALTH BENEFIT FUND ("FUND") currently provide our members' prescription drug coverage, which is administered by Benecard PBF.

The DEA "FUND" has been deemed actuarially equivalent to the Medicare Part D government program. We are required to provide you with a "NOTICE OF CREDITABLE COVERAGE," which can be found in the Health Benefits section of this Web site.

PLEASE DOWNLOAD THIS INFORMATION AND PUT THE DOCUMENT IN A SAFE PLACE.

The enrollment period for Medicare Part D occurs November 15, through May 15 each year. Should you decide to enroll in Medicare Part D after the annual enrollment period, you must provide the above referenced documents to avoid a late filing penalty.

Medicare Part D and Your Fund Coverage

If you do not opt for the Medicare Part D coverage, you will continue to receive full prescription drug benefits available to you under the Fund's plan. The decision whether or not to enroll in Medicare Part D should be made after you review the benefits provided under Medicare Part D. This is an individual decision dependent upon your individual circumstances.

Unless you or a dependent incur prescription bills in excess of the DEA's $15,000 retiree annual cap, it would be in your best interests to *remain with the DEA's coverage*.

In addition:

- There will be ***no change*** in your drug benefits simply because of your (or your dependent's) eligibility for Medicare;
- You will not be required to enroll in Medicare Part D;
- Please note that if you ***do*** enroll in Medicare Part D, it will be your primary and ***only*** drug coverage and you will no longer be enrolled in the DEA prescription drug plan as of the Medicare Part D effective date.

If your spouse/dependent is not eligible for Medicare Part D and you elect to take Medicare Part D, the DEA ***cannot*** cover your spouse/dependent under the DEA prescription drug plan.

If you have any questions please feel free to contact the DEA Funds office at **212.587.9120**.

See the Health Benefits portion of this Web site to download and save the important NOTICE OF CREDITABLE COVERAGE.

Optical Plan

OPTICAL BENEFITS

The Detectives' Endowment Association Retirees' 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 Vision Screening and Davis Vision, Inc.

Effective January 1, 2010, two vision vendors are available for retirees who reside in New York or New Jersey, Vision Screening and Davis Vision. Vision Screening will provide a vision exam, frames/lenses or contacts at no charge in New York State and for a $15 copayment in New Jersey. Davis Vision will provide a vision exam, frames/lenses or contacts for a $25 copayment in New York State. For out of state (non-New York) retirees, Davis Vision is the sole vendor and will provide an exam, frames/lenses or contacts for a $67 copayment ($25 basic eyewear + $42 basic exam). You may choose from the selection of Davis Vision "Designer" frames at any participating Davis Vision provider. Should you wish to upgrade your frames to Davis Vision's "Premier" frame selection, you may do so for an additional $25.

As of January 1, 2010, optical certificates are no longer required as eligibility is maintained by both Vision Screening and Davis Vision. Appointments can be scheduled directly at the participating provider's office by providing your DEA unique ID number.

Lastly, in addition to the elimination of the vision voucher requirement, the new retiree vision benefit replaces the previous $32.50 eye examination/eye glass benefit and $10 examination only benefit, effective January 1, 2010.

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**.

Optical Plan (continued)

How Do I 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. For Vision Screening you may telephone them at **800.652.0063** or visit them online at **www.vscreening.com** to obtain information about their participating providers.
- 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.

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.
- Non-prescription (Plano) lenses.
- Services not performed 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 eligible dependents 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.

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.

Catastrophic Coverage Plan

CATASTROPHIC COVERAGE PLAN FOR GHI MEMBERS

The Detectives' Endowment Association Retirees' Health Benefits Fund provides a Catastrophic Coverage Plan for GHI non-Medicare eligible members.

Who Is Covered?

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

What Is the Benefit?

The Catastrophic Medical Plan supplements the major medical benefits provided under the City's GHI CBP plan in the event of catastrophic illness. The plan pays 100% of eligible expenses after a $4,000 annual deductible per family unit has been reached.

Eligible expenses are those covered under GHI's non-participating provider schedule of allowances, considered reasonable and customary by GHI and not reimbursed in full by the City health plan or any other health insurance coverage.

If I have medical coverage under the City Plan, why do I need catastrophic coverage?

Under the City plan, eligible members and their dependents have the option of receiving medical services from a non-participating medical care provider at a reduced rate of reimbursement. The catastrophic medical coverage is provided to protect those members who select this option from any large out-of-pocket expenses, which may occur.

Doesn't GHI cover catastrophic expenses under the basic program as well?

The catastrophic coverage provided under the basic program is limited to in-hospital care, such as expenses relating to surgery, anesthesia, maternity care, and in-hospital lab and X-ray. The catastrophic coverage under the City's GHI CBP plan excludes non-hospital expenses. Since non-hospital expenses can be substantial when acute care is required, the Fund's catastrophic coverage provides you with added protection.

Are there any charges that the plan does not cover?

The plan does not cover any charges that are covered under the City's optional rider. For instance, prescription drug charges are excluded. Any charges that are excluded under the basic plan are also excluded under the Catastrophic Coverage Plan. GHI must make some level of payment under their non-participating schedule of allowances in order to qualify for the DEA's supplemental catastrophic medical coverage.

Are there any benefit limits or maximums?

Yes, there is a lifetime maximum benefit of $250,000 **per family**.

Catastrophic Coverage Plan (continued)

How Do I Obtain the Benefit?

The Catastrophic Coverage plan is self-insured by the DEA Retirees' Health Benefits Fund and claims must be submitted in accordance with the Fund's claims submission process.

CATASTROPHIC COVERAGE DEDUCTIBLE REIMBURSEMENT BENEFIT

Who Is Covered?

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

What Is the Benefit

The Fund will reimburse the member $3,000 of the $4,000 annual deductible per family unit required under the GHI Catastrophic Coverage plan, once per calendar year, once it has been confirmed that the full deductible has been met.

How Do I Obtain the Benefit?

- Telephone or write to the Fund office to obtain a claim form.
- Complete the claim form and submit it to the Funds office with your Explanation of Benefits ("EOB") statement(s) from GHI describing the medical expenses you incurred.

Once it has been confirmed from your Explanation of Benefits (EOBs) that you have met the $4,000 annual deductible, you will receive your reimbursement from the Fund.

Equipment and Nursing Plan

DURABLE MEDICAL EQUIPMENT AND PRIVATE DUTY NURSING BENEFITS

Rider to HIP HMO Contract

The Detectives' Endowment Association Retirees' 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, not a relative of someone who simply 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.

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;

Equipment and Nursing Plan (continued)

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.

GHI-CBP OR HIP-VIP COPAYMENT REFUND BENEFIT

There is a $5 refund on your copayment for physician's office visits for members of the GHI-CBP and HIP-VIP City of New York Health Benefit programs. You may submit up to 15 office visit copayments per family per year.

Exclusions or services not covered under the DEA copayment refund are as follows:

- Physician office visits for a period beyond the previous calendar year
- Lab Tests
- X-Rays, Blood Work, MRIs, Sonograms
- Allergy Injections
- Psychological Pharmacy Management
- Hearing Evaluation
- Physical Speech Therapy

Other exclusions may apply that are not listed above.

Retirees should telephone the DEA Health Benefits Office at 212.587.9120 each January for a refund form. Filing for refunds falls between January 1 and March 31 for your previous year's physician visits. All refund checks are mailed to our retirees each April.

Body Scan Plan

FULL-BODY SCAN DISCOUNT BENEFIT

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

Who Is Covered?

All covered members and their eligible dependents.

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 $375.00.

Your eligible dependents may also receive one (1) full body screening per lifetime through Inner Imaging, P.C. for the same discounted fee of $375.

How Do I Obtain the Benefit?

Contact Inner Imaging directly at **212.777.8900** to schedule an appointment for a full-body scan screening.

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.**

What To Do If You Become Eligible for Medicare

MEDICARE PART B REIMBURSEMENT

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The City of New York Health Benefits Program provides a second level of benefits to fill certain gaps in Medicare coverage. **In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) at your local Social Security office AS SOON AS YOU BECOME ELIGIBLE.**

If you do not join Medicare, you will lose whatever benefits the City would have provided. The City of New York Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare. Additionally, should you not elect Medicare Parts A and B, you will be charged a significant penalty at a later date should you wish to obtain Medicare benefits. This penalty will apply each and every year in the form of a significantly higher Medicare Part B premium rate until you reach age 65. Also, Medicare-eligibles must be enrolled in Medicare Parts A and B in order to be covered by a Medicare HMO plan. The City of New York continues to reimburse 100% of your Medicare Part B premium on an annual basis. There is no charge for Medicare Part A. You must provide a copy of your Medicare card and completed Medicare Reimbursement Application to the City of New York Health Benefits Program in order to receive your annual Medicare Part B reimbursement. Please note that should your spouse also be Medicare eligible or becomes Medicare eligible in the future, the same reimbursement of Medicare Part B premiums would be available through the City of New York. Medicare Reimbursement Applications should be mailed to The City of New York Health Benefits Program, 22 Cortlandt Street, 14th Floor, New York, NY 10007.

IRMAA MEDICARE PART B REIMBURSEMENT

A new federal law requires that some beneficiaries pay a higher premium for Medicare Part B coverage based on their income. If you and/or your eligible dependent paid a Medicare Part B income-related monthly adjustment amount (IRMAA) during the calendar year, which means MORE than the standard Medicare Part B premium, you may be entitled to an additional reimbursement (surcharge for late enrollment does not qualify as an amount that is eligible for additional reimbursement).

To claim the additional reimbursement you are required to document the eligible amount paid in excess of the standard premium as indicated on your Social Security Administration (SSA) statement issued at the end of each calendar year. Details on how to obtain the necessary forms needed for submission to the City of New York Health Benefits department can be obtained from your local Social Security office or on line at: **http://www.socialsecurity.gov/onlineservices**. This website can also be accessed to request a copy of the SSA-1099 which is also required in order to receive your City of New York refund.

Once completed, copies of the SSA statement and SSA-1099 should be submitted **for each eligible person**, along with a completed Submission Form (available at **http://nyc.gov/html/olr/html/health/health_benefits_prog.shtml**) to:

City of New York, Office of Labor Relations
Health Benefits Program
22 Cortlandt Street, 14th Floor
New York, NY 10007
Attention: IRMAA
General Information: 212.306.7200
Fax: 212.306.7202

This benefit summary prepared by

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Insurance | Risk Management | Consulting

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