125 Barclay Street
New York, NY 10007
Telephone :(212) 815-1234

Health & DC37 Security Plan

December 2025

RE: Local 1070 Prescription Drug Co-Payment Reimbursement Benefit

Dear Local 1070 NYS Active/Retired Bargaining Unit Member:

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

For Calendar Year 2025, Participants may receive reimbursement for prescription drug co-payments up to a maximum of $300 per family when they spend at least $1. ***Only one reimbursement request per family is permitted.***

For example:

> *If the total out-of-pocket prescription drug co-payment for you and your family for the period from January 1, 2025 to December 31, 2025 was $150, you are eligible for a reimbursement of $150.*
>
> *If the total out-of-pocket prescription drug co-payment for you and your family for the period from January 1, 2025 to December 31, 2025 was $400, you are eligible for a reimbursement of $300, which is the maximum benefit amount.*

Please complete the enclosed application and submit it for payment along with an Explanation of Benefits (EOB) statement from your prescription drug benefit provider documenting your total out-of-pocket prescription drug co-payments for the calendar year 2025. The EOB statement must be attached to the application. Your application will not be processed without the EOB statement. The application and EOB statement must be returned to the Plan's office, in the enclosed self-addressed envelope **no later than April 30, 2026**.

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

If you have any questions regarding this benefit, please contact the DC37 Health & Security Plan's Drug Unit at 212-815-1621.

In Solidarity,

William Bifulco
Administrator
DC37 Health and Security Plan

cc: Renee Belmar, President – Local 1070

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

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

PRESCRIPTION DRUG CO-PAYMENT REIMBURSEMENT CLAIM – 2025

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

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

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

Please check one: _____ Local 1070 Active Bargaining Unit Member
_____ Local 1070 Retiree

Personal Identification Number (PID) or SS#_____

Signature: _____ Date: _____

To obtain your reimbursement of out-of-pocket prescription drug co-payments per individual/family for the period January 1, 2025 through December 31, 2025, please: 1) Complete and sign the above application; 2) Attach a copy of your Explanation of Benefit Statement (EOB) obtained from your prescription drug benefit provider (Empire Plan or your HMO) documenting your total co-payments for the calendar year 2025; and, 3) Send both to the DC 37 Health & Security Plan, 125 Barclay Street, New York, New York 10007, Attn: Drug Unit.

Applications submitted without an EOB statement cannot be processed and will be returned to you. (Individual receipts will not be accepted). To qualify for reimbursement, please submit your total out-of-pocket prescription co-payments over $1 for Calendar Year 2025. The Health & Security Plan will reimburse you up to a maximum of $300 in out-of-pocket prescription drug co-payment expenses. All applications for reimbursement must be received **no later than April 30, 2026**. For assistance in completing this application you may contact the Plan's Drug Unit at (212) 815-1621.

(This section to be completed by DC37 H&S Plan Staff Only)

EOB attached: ____ YES _____NO

Total prescription drug co-payment:_____ Reimbursement Amount: _____

Prepared by: _____ Date: _____

Reviewed/Approved By: _____ Date: _____

Date sent to Accounting: _____