Chappaqua Congress of Teachers Benefit Fund

Benefits Booklet

PROUDLY
SERVING
OUR MEMBERS'
NEEDS

DENTAL BENEFITS

VISION BENEFITS

GROUP TERM LIFE INSURANCE

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

LEGAL SERVICES PLAN

FINANCIAL COUNSELING PROGRAM

Chappaqua Congress of Teachers
Chappaqua, NY 10514

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Benefit Summary

Chappaqua Central School District Employee Benefit Fund

Dental

Services	In-Network	Percentage Paid Out-of-Network (R&C)
Preventive Services*	100%	80%
Emergency Palliative Treatment Oral Examination 3 per policy year X-rays bitewings full mouth series every 3 years Bitewings – no more than 8 films per policy year Teeth Cleaning – 3 per policy year Fluoride Treatments for Children (2 per policy year to age 19) Topical Sealants for unrestored molar teeth covered		
Basic Services	80%	80%
Laboratory Test Fillings: Amalgam, Silicate & Acrylic Crowns: Stainless Steel Repairs of dentures, bridgework, crowns, etc. Endodontic Services/Root Canal Therapy Periodontal Services Oral Services – Uncomplicated extractions General Anesthesia – surgical procedures only Injectable Antibiotics – for treatment of a dental condition only.		
Major Services	80%	80%
Bridges Installation-fixed and removable Dentures-Full and Partial Crowns: Acrylic Metal, Porcelain Inlays Onlays Posts Implants		
Orthodontic Services	80%	80%
$3,000 Lifetime Maximum for child(ren) under age 19 (amount paid for orthodontics is included in your plan year maximum)		

- There is a $3,000 annual maximum for Preventive, Basic and Major services combined, subject to the maximum rollover. A maximum of $5,000 per family per plan year.
- Children are covered up to age 19 or 25 if a full time student.
- Employee/Dependents enrolling outside of the plan eligibility period may be subject to Late Entrant penalties with a $500 family maximum for the first year.

- All out of network services are based on usual, reasonable, and customary rates for given area.
- Dental Claims – P.O. Box 9182, Farmingdale, NY 11735
  Ph – (800) 321-1336 or (516) 777-4800
- Fitzharris has contracted with dental providers to provide discounts off services and procedures to Fitzharris' dental plan members. To locate a provider, please reference our on-line Provider Directory at www.fitzharrisinsurance.com. We have also contracted with Aetna Dental Administrator Network.
- Predetermination Review – Fitzharris will gladly assist you and your dentist by determining what benefits are payable for services and procedures of $300 and more. Have your dentist send your treatment plan to Fitzharris. Note that it is a predetermination review and we will let your dentist know what benefits would be payable. (This includes orthodontic treatment if your plan includes it) **Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.

General Limitations and Exclusions: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made.

CHAPPAQUA CONGRESS OF TEACHERS BENEFIT FUND

WHERE TO FIND CLAIM FORMS:
Forms are found on the Chappaqua Congress of Teachers' website at http://www.cctbf.com/#!forms/ca4p, the Main Office of each School and/or on the Fitzharris website at www.fitzharrisinsurance.com.

ELECTRONIC CLAIMS FILING:
Electronic claims for our self-funded accounts can be submitted by your provider. Fitzharris' payer number is 11244 for dental/vision claims.

WHEN SHOULD YOU SUBMIT A CLAIM?
When you have a claim, you should promptly submit the completed claim form and any bills or receipts. **Claim forms must be fully completed by all parties (provider and member) and filed within 90 days from the close of the plan year. The plan year is July 1 – June 30.**
Please note: Benefit checks may have an expiration date. Please cash promptly.

HOW TO FILE YOUR CLAIM FORMS:

- Complete the entire Employee portion of the Claim Form.

- If the Claim is for yourself, your coverage is the primary plan. If the claim is for your spouse and he/she has other coverage, be sure to attach the Explanation of Benefits (EOB) or declination from his/her plan. If the claim is for your dependent children and your birthday (month and day) is earlier in the calendar year than your spouse's, you should file first. If your spouse's birthday is earlier, you must file with your spouse's plan first, and attach copies of his/her EOB to the claim you are filing through our plan. For additional information regarding duplicate benefits refer to page 13.

- Attach provider's itemized bill(s) or have the provider complete his or her portion of the form.

- Completed forms should be mailed to the Claims Administrator, Fitzharris Benefits Administrators, P.O. Box 9182, Farmingdale, New York 11735-9182.

- Questions regarding coverage should be directed to Fitzharris Benefits Administrators at 800-321-1336 or 516-777-2244.

COMMON CLAIM PROBLEMS

- Incomplete information regarding whether you or your spouse has other group insurance coverage, and if so, name of group, name of insurance company, address, policy number, etc. If there is other group coverage, send a copy of the EOB furnished by the other plan.
- Incomplete information regarding dates of birth.
- Unsigned claim forms, missing procedure codes.
- Failure to submit full-time student verification.
- Failure to submit claims within 90 days of end of plan year.
- Failure by dentist to provide age of prior placement when seeking replacement of crown, denture, or fixed bridgework.
- Failure to update your provider of administrative changes.

MAY WE REQUIRE ADDITIONAL PROOF OF CLAIM?

Yes. Before paying benefits, we can require the following:

1. A dental chart showing work done before the treatment for which claim is made.
2. X-rays, lab or hospital records.
3. Cast molds or other evidence of the dental condition of treatment.
4. Post-treatment examination of the patient, at our expense, by a dentist we select.

SHOULD YOU KEEP RECORDS OF EXPENSES?

You should save all bills and receipts for dental expenses. We need them as proof of your claim.

DENTAL PLAN
DESCRIPTION OF BENEFITS

The following benefits are payable, subject to the other provisions and limitations of the plan, for "Covered Dental Services".

A. Amounts of Benefits - When an eligible participant and his/her lawful dependents have incurred covered dental charges for services, supplies or treatment furnished, the Fund will pay a level of benefits as indicated in the Schedule of Benefits Supplement.

B. Maximum Benefits - Benefits payable to an eligible participant and dependents in any plan year are limited. **Please see the Schedule of Benefits Supplement for the current maximum amount.**

C. New employees and family members have limited benefits during the first year of participation. **Please see the Schedule of Benefits Supplement for the current maximum amount.**

SCHEDULE OF DENTAL BENEFITS

PLAN EFFECTIVE DATE: July 1, 2001

PLAN'S LAST REVISION: April 1, 2008

EMPLOYEE ELIGIBLE: As defined on Page 4

DEPENDENTS ELIGIBLE: All dependents as defined on Page 4

PARTICIPANT'S CONTRIBUTION:
As determined by the Trustees of the Chappaqua Congress of Teachers Benefit Fund

DENTAL BENEFITS FOR YOU AND YOUR DEPENDENTS:

Reimbursement is based on a level of allowances (allowable charges) determined by the Trustees of the Employee Benefit Fund as indicated in the Benefit Supplement.

For more details consult your Claims Administrator, Fitzharris Benefits Administrators

IMPORTANT: Read this document carefully. See "DEFINITIONS" and "WHAT EXPENSES ARE NOT COVERED" for other conditions that may affect the coverage.

Please refer to the Schedule of Benefits Supplement for the following:

- New member's maximum
- Returning member maximum
- New member eligibility
- Orthodontic payment plan and maximum

WHO IS ELIGIBLE FOR COVERAGE?

ACTIVES:

Any Employee for whom contributions are made to the Chappaqua Congress of Teachers Benefit Fund pursuant to any collective bargaining agreement, individual contract of employment or school board policy.

Your following dependents, if any, are also eligible for coverage:

1. Legal spouse.
2. Same sex, Domestic Partners as defined by the District's Health Plan.
3. Each of your unmarried children who are under 19 years of age; or who are full-time college students under 25 years of age and are dependent upon you for support; or stepchildren, adopted children, or foster children who are dependent upon you for support. (Full-time student status is defined as carrying at least 12 credits.)

Exceptions - The dependent age limit does not apply to handicapped dependent children. You may be required to show proof of handicapped status once a year.

Mentally or Physically Handicapped Children

If a Covered **Dependent** child:

(a) reaches the age at which he would otherwise cease to be a Covered **Dependent**; but
(b) is then mentally or physically incapable of earning his own living; and
(c) is primarily dependent upon you for support; and if
(d) you submit satisfactory proof of the child's incapacity within 31 days of the date the child reaches such age, then coverage may continue for such child for as long as he remains incapacitated, subject to payment of required contributions and all other terms of the plan.

Late Subscriber Provision – Your plan requires an annual contribution for family coverage. Those eligible for family coverage must enroll their dependents within 30 days of their eligibility in order to avoid the new member limitation as explained in the Schedule of Benefits Supplement. The first year maximum begins from enrollment. If you cancel family coverage and re-enroll for family coverage at a later time, you and your eligible dependents will also be subject to the first-year new member limitation maximum.

HOW DO YOU ENROLL?

You enroll for coverage by completing a Request for Coverage Form which is given to eligible members at the time of hire. If you wish to cover any eligible dependent, you must elect coverage for all of your eligible dependents. If you do not have any eligible dependents when you enroll, you may apply for dependent coverage when you acquire an eligible dependent. You must enroll within 30 days and pay the required contribution or you will be considered a late subscriber. The contribution is determined by the trustees prior to the new plan year (7/1 to 6/30).

WHEN DO BENEFITS BEGIN?

Coverage for you and your dependents begins on the first day of the month nearest to the date you are employed and begin work.

New employees and family members have limited benefits during the first year of participation. **Please see the Schedule of Benefits Supplement for the current maximum amount.**

DEFINITIONS

Allowable Charge

A charge which is included in the list of covered expenses and does not exceed the allowances adopted by the Trustees.

Alternative Benefits

If:

(1) there is a less costly alternative to any service or supply which is proposed, furnished, or provided; and

(2) such alternative is within accepted standards of dental practice; then only the allowable charge for such alternative shall be considered to be a Covered Expense.

Benefit Year

A 12 month period beginning July 1 and ending June 30th.

Claims Administrator

Fitzharris Benefits Administrators

Covered Expense

A service or supply which appears on a list of covered expenses.

Dental Hygienist

A person who:

- is licensed to practice dental hygiene; and
- works under the direct control and supervision of a **Dentist.**

Dentist

A licensed **Dentist** who is practicing within the scope of his license.

E.O.B. "Explanation of Benefits"

Voucher which accompanies claim payment that describes dated services performed.

Family Member

Refers to you or any of your eligible dependents covered under the plan.

Incurred Expense

An expense is deemed to be incurred on the date a service is rendered or a supply is furnished except for the following:

- Expense for an appliance or modification of an appliance is deemed to be incurred on the date the master impression is made.
- Expense for a crown, a bridge, or an inlay or onlay restoration is deemed to be incurred on the date the tooth is prepared.
- Expense for root canal therapy is deemed to be incurred on the date the pulp chamber is opened.

Late Subscriber

A member who does not enroll his or her family members within 30 days of eligibility must wait until the next open enrollment period.

Lifetime Maximum Benefit

The total amount of benefits which will be available to a covered person during his/her lifetime. The orthodontic maximum is a combined maximum subject to the individual and/or family plan year maximum.

Maximum Benefit

The total amount of benefits which will be available to a Covered Person or Covered Persons during a benefit year.

Necessary Service or Supply

A service or supply which is generally considered by **Dentists** to be an appropriate dental service or supply for a given dental condition.

For purposes of this plan, The Plan Administrator and Trustees reserve the right to determine:

(1) **Usual Charges**; and
(2) **Customary Charges**; and
(3) **Allowable Charges**; and
(4) **Necessary Services or Supplies**

Plan Administrator – Chappaqua Congress of Teachers Benefit Fund

Participant - You and your eligible dependents

Pre-Determination of Benefits

A **Dentist's** report to the Claims Administrator which:

- is on a claim form; and
- lists the services he or she proposes to render to a **Covered Person**; and
- shows his/her charge for each service; and
- is accompanied by pre-treatment x-rays or other diagnostic data which The Claim Administrator may require

DENTAL CARE BENEFITS

WHAT DO WE PAY?
We will pay a Covered Expense up to the allowable charge for Preventive, Diagnostic, Basic, Major and Orthodontic services.

Is There a Maximum Benefit?
The maximum we will pay for all Covered Expenses, including orthodontia, during a benefit year is indicated in the Schedule of Benefits Supplement.

Should Benefits Be Determined Before Treatment Starts?
One of the advantages of our dental plan is that it enables you to see the amount payable by the plan prior to having your dentist begin any extensive treatment. This procedure is known as a Pre-determination of Benefits. Through this process, you can prevent any misunderstanding as to what is covered by the dental plan. **Benefits should be pre-determined before you begin treatment if the charges for the treatment will be more than $500.** Benefit determination will be made by the Claims Administrator. Our standard dental claim form should be completed and submitted to the Claims Administrator. The Claims Administrator will advise you and your dentist of the approved covered dental procedures.

What If More Than One Method Of Treatment Is Available?
When more than one method of treatment is available, we will pay for Covered Expenses for the least expensive method of treatment, regardless of which method is actually used. Examples of this are: restoring teeth with an inlay, onlay, or crown when the tooth could be restored with a filling; fixed bridgework when a partial denture would provide a similar result. Benefit determination will be made by the Claims Administrator.

WHAT ARE COVERED EXPENSES?
Covered Expenses are CHARGES by a dentist for necessary dental services furnished to a covered person under the Plan, which do not exceed the allowable charge. There are four types of Covered Expenses: Preventive Expenses, Basic Dental Expenses, Major Dental Expenses and Orthodontic Expenses. Not all expenses are covered. See--WHAT EXPENSES ARE NOT COVERED?

Covered Charges -
Preventive Services

- Cleaning and scaling teeth (prophylaxis) 3 times each Benefit Year.
- Fluoride treatments for a child's teeth twice each Benefit Year, limited to children under age 19.
- Space maintainers and their fitting. For children only.
- Sealants – limited to permanent molar teeth, one per tooth in any 36-month period to age 15.

Diagnostic Services

- Routine oral exams 3 times each Benefit Year.
- X-rays and laboratory tests needed to diagnose a dental problem or to check the progress of treatment.
- Full mouth X-rays as part of a routine exam once every 36 months.
- Bitewing and other X-rays as part of a routine exam twice each Benefit Year, no more than 4 X-rays for any on oral exam.

Basic Services

- Removal of teeth (extractions) and cutting procedures in the mouth (oral surgery). Treatment of jaw fractures and dislocations are also covered when not covered by your medical plan. Extra charges for removing stitches and exams after surgery are not covered.
- Root canal work (endodontic treatment), including x-rays.

- Scaling/root planning and osseous surgery require periodontal charting.
- Scaling/root planing limited to 4 quadrants per year code (4341).
- Osseous surgery--once in each 5 year period.
- Periodontal maintenance code (4910)--considered a maintenance service and subject to two treatments per benefit year.

- Anesthesia – A separate charge for general anesthesia is covered in conjunction with partial and full bone extraction, osseous (bone) surgery, fractures or dislocation. A charge for local anesthesia is not covered, as it is included within the normal charge for the treatment for which the local is given.
- Medication – The plan covers charges for injectable antibiotics administered by a dentist or physician for covered dental care.
- Silver (amalgam) and composite fillings. Fillings involving the same decay are not covered within 2 years of date of first filling.
- Repairs to broken crowns, inlays, bridgework and dentures. This does not include adjustments made to new dentures or bridgework during the first 6 months after they are installed. Those charges are considered to be included in the cost of the new denture or bridgework. Extra charges are not covered.
- Rebasing or relining dentures which are over 6 months old. If the benefit pays for a new denture, it will not pay to rebase or reline the old denture.
- Adding teeth to fixed bridgework or partial dentures to replace missing natural teeth. The teeth that are being replaced must be lost while the person is covered.

Major Services Restorative Services and Supplies

- Crowns and gold fillings or porcelain inlays and onlays to repair a tooth broken down by decay or injury subject to the following conditions:

  Charges for these restorations are covered only if the tooth cannot be repaired with a less expensive type of filling. If the tooth can be repaired by a less expensive method, only that charge will be covered.
- Charges for replacement crowns, gold fillings, inlays and onlays are covered only if the prior placement is over 5 years old. **This provision will not be waived for any reason.**

Prosthetic Services and Supplies (Dentures and Fixed Bridges)

- Full or partial dentures and fixed bridgework to replace missing natural teeth. The teeth that are being replaced must be lost while the person is covered under this plan.

- Full or partial dentures and fixed bridgework to replace an existing denture or bridge that cannot be made serviceable. The existing denture or bridge must be over 5 years old. **The plan will not cover a replacement in less than five years for any reason.**

Charges for special techniques or precision attachments are not covered. Charges for any special work that you ask to have done on a standard denture are not covered. Charges made for adjustments to new dentures or bridgework during the first 6 months after they are installed are not covered. Those charges are considered to be included in the cost of the new denture or bridgework. Extra charges are not covered.

A permanent denture may replace a temporary one. In this case, charges for both are limited to the charge for the permanent one.

- **Implants**

ORTHODONTIC SERVICES
DESCRIPTION OF SERVICES

There is a maximum lifetime orthodontic benefit. **Please see the Schedule of Benefits Supplement for the current maximum amount and method of payment.** Adult orthodontia is covered if one of the following conditions exists:

- extreme bucco-lingual version of teeth, either unilateral or bilateral;
- a protrusion of maxillary teeth of more than 4 mm;
- a protrusive relation of the maxillary or mandibular arch of at least one cusp;
- an arch length discrepancy of 4 or more mm.

Payment will be made for active monthly treatment only. Retainers are considered part of the total treatment plan, and therefore are not a separate expense.

If a new member's dependent child is already in orthodontic treatment on the date they become eligible for orthodontic coverage, the following formula will apply. Twenty-four (24) months will be considered a full case. The plan will subtract the number of months already in treatment from 24 and pay the maintenance allowance for the remaining months.

Payments will be made up to the scheduled allowances for the covered orthodontic charges described above which are incurred while eligible, up to the maximum lifetime benefit.

WHAT EXPENSES ARE NOT COVERED?

The following charges are **not** covered or are covered only to the extent stated.

1. OCCUPATIONAL INJURY--Charges due to an on-the-job injury are not covered. However, this exclusion will not apply if the law does not permit a family member's employer (or the family member) to obtain coverage for the family member under a Workers' Compensation Act or similar act. Nor will it apply if the law permits but does not require a family member who is a partner or an individual proprietor to have coverage under a Workers' Compensation Act or similar act and that person does not have such coverage.
2. OCCUPATIONAL SICKNESS--Charges due to any sickness which would entitle the family member to benefit under a Workers' Compensation Act or similar act are not covered.
3. GOVERNMENT SERVICES--Charges for dental services furnished by or paid for by any government or government agency are not covered. Charges for dental services are not covered if the family member would not have been required to pay for the services in the absence of insurance for dental care. However, this exclusion will not apply where prohibited by law.
4. COSMETIC DENTISTRY--Charges in connection with dental services primarily for the purpose of improving appearance are not covered. For example, the following are not covered:
   (i) alteration or extraction and replacement of sound teeth.
   (ii) porcelain or other veneer crowns or pontics to replace molar teeth, porcelain or other veneer facings on crowns or pontics to replace molar teeth, composite or plastic fillings placed in molar teeth, precision or semi precision attachments.
   (iii) whitening or bleaching of teeth.
5. Replacement of existing dentures or fixed bridgework, or addition of teeth to existing dentures or fixed bridgework, unless:
   (i) the replacement or addition is needed to replace at least one natural tooth extracted while covered under the Dental Plan; or
   (ii) the existing denture or fixed bridgework was installed at least five years prior to the replacement and cannot be made serviceable.
6. Replacement of lost or stolen dentures or fixed bridgework.
7. Appliances, restorations, or procedures for:
   a. altering vertical dimension; or
   b. restoring or maintaining occlusion; or
   c. splinting; or
   d. replacement of tooth surface lost by abrasion or attrition; or
   e. treatment of dysfunction of the temporomandibular joint (TMJ), unless specifically included in your booklet.
   f. crowning of the teeth for periodontal support.
8. MISCELLANEOUS SERVICES--Charges for oral hygiene instruction, plaque control, dietary instructions.
9. The benefit fund plan document indicates time restrictions before certain expenses are covered. The Trust will not waive these restrictions.

10. Any service or supply which is not customarily performed, not reasonably necessary for dental care or treatment, or is experimental in nature.
11. Any service or supply which is not furnished by a Dentist, except:
    a. A service performed by a Dental Hygienist working under supervision of a Dentist; and
    b. X-rays ordered by a Dentist.
12. Charges for services which you would not normally be required to pay in the absence of this coverage. For example, services performed by a family member related by blood or marriage.

TREATMENT STARTED BEFORE COVERAGE BEGINS--
Charges for the following are **not** covered:

Dentures, if the impression for the denture was taken before coverage begins under the Dental Care Plan; crowns, bridges or gold restorations if preparation of the tooth was started before coverage begins under the Dental Care Plan; and root canal therapy, if started before coverage begins under the Dental Plan.

Orthodontic charges which were charged prior to the participant's effective date of coverage.
The orthodontic maximum will be reduced by all orthodontic services rendered prior to the effective date of coverage.

DUPLICATE BENEFITS

HOW DO OTHER GROUP TYPE PLANS AFFECT BENEFITS?
If a person has coverage under another plan which is considered the primary plan as per the definition below, we will coordinate our benefits with those of the primary plan. If charges are not paid in full by the primary plan, we will consider the outstanding balance and pay an amount which, when added to the benefits paid by the primary plan, will not exceed the dentist's actual charge. In no event, will our plan pay more than the "allowable charge" as defined. "ALLOWABLE CHARGE" which means the usual and customary charge which falls within the scheduled allowance adopted by the Trustees for an item of care at least part of which is covered by one of the plans.

A plan that does not coordinate with other plans is always the primary plan. If both plans coordinate, the primary plan is determined as follows:

1. The plan which covers the patient as an employee, rather than as a dependent, is primary.

2. If both plans cover the patient as a dependent child, the following will determine which plan is primary:
   (a) The primary plan will be the plan of the parent whose birthday occurs earlier in the calendar year, except that:-If both parents have the same birthday, the primary plan will be the plan which has covered the parent for the longer period of time. "Birthday" refers only to month and day in a calendar year, not the year in which the parent was born.-If either parent plan is issued in another state and does not have this rule for determining which plan is primary, but instead has a rule based upon the gender of the parent, the plan with the gender rule shall determine which plan is primary.
   (b) If the child's parents are separated or divorced, the primary plan will be the plan of the parent with custody of the child, except that:-If the parent with custody is covered as the spouse of the child's stepparent, the primary plan will be the plan of the stepparent.-If a court decree has said which parent has financial responsibility for the child's covered expenses, the primary plan will be the plan of the parent who has that responsibility if the insurer of that plan has actual knowledge of the terms of the decree. This does not apply to any claim determination period or plan year during which benefits are paid before the insurer had that actual knowledge.

3. If neither 1. nor 2. applies, the primary plan will be the plan which has covered the patient for the longer period of time, except that:

(a) If the coverage of one plan is based on present employment, and the coverage of the other plan is based on prior employment, the primary plan will be the plan which is based on present employment; and

(b) If either plan is issued in another state and does not have this rule for determining which plan is primary, this rule will not apply.

HOW DOES NO-FAULT AUTO INSURANCE AFFECT BENEFITS?
We will reduce the benefits we would normally pay due to injuries from an automobile accident, so that our benefits plus NO-FAULT BENEFITS do not exceed 100% of the covered expenses for such injuries.

"NO-FAULT BENEFITS" means the minimum level of personal injury benefits which state law requires to be offered under automobile insurance policies and which would be paid, regardless of fault, if claim had been made for such benefits.

WHEN DOES YOUR COVERAGE END?
Your coverage will end on the last day of the Plan month during which any of the following events occur:
1. Your employment ceases; i.e. you cease active full-time work in the eligible classes;
2. You stop making any required payments for your coverage;
3. The Plan terminates.

LEAVE OF ABSENCE
Any member of the Trust granted a leave of absence by the Board of Education after at least one year of continuous membership in the Trust, may maintain his/her membership through direct personal payment to the Trust. Payment will be required in full within 30 days of last day worked and will be equal to the amount that would have been due from the Board of Education. In the event payment is not received within 30 days, membership will be terminated. If membership is not maintained, the member, upon return, will be subject to all rules affecting new members. The Trust will provide this service for a member on leave for a maximum of one year, unless extended by a vote of the Trustees.

Under the Family Medical Leave Act, all benefits are maintained for 12 weeks. The employee may extend this benefit by paying the premium as detailed in the above paragraph.

WHEN DOES DEPENDENT COVERAGE END?
Dependent coverage will end on the earliest of the following events:
1. Your coverage ends;
2. The dependent ceases to be an eligible dependent;
3. Termination of coverage for a post-secondary student not returning to school is 30 days from the last day of enrollment;
4. You stop making any payments required for dependent coverage;

ARE BENEFITS PAID AFTER COVERAGE ENDS?
We will pay Dental Care benefits for the following services incurred within 30 days after coverage ends:

1. A denture for which an impression was taken before the coverage ended; and

2. A crown, bridge, or gold restoration for which preparation of the tooth was begun before coverage ended; and

3. Root canal therapy if started before the coverage ended.

VISION CARE EXPENSE BENEFIT

Effective June 1, 2012, the Fund is establishing the vision coverage through Solstice Benefits, Inc. Under this program, members and eligible dependents have the option of utilizing an in-network provider (Davis Vision is the Solstice Benefit's vision network). If an-network provider is utilized, the plan will provide enhanced benefit. See the fund booklet for further details. If a member chooses not to use a network provider, he/she is able to use any vision provider.

Vision Care Cash Deductible – None
(Each Covered Person – per Plan Year)
Payment Percentage – The plan pays 100% of the Schedule shown below:

Procedure:	
Eye Examination, Non Medical Diagnosis	$75
Frames	$200
Lenses:	
A. Single	$90
B. Bi-focal	$155
C. Tri-focal	$200
D. Lenticular	$200
E. Contacts	$290

A Routine Eye Examination is covered once every 12-months. Benefits Eyeglasses / Contact Lenses are paid once every 12 months.

The plan will only pay amounts up to the actual charge and is not responsible for charges in excess of the schedule. Glasses are covered if a visual deficiency exists.

For more details, consult our Claim Administrator, Fitzharris Benefits Administrators.

In-Network Benefits		Designer Vision Plan (Two-Pair Benefit[/1])
Frequency – Once Every:		**Plan Design**
Eye Examination inclusive of Dilation (when professionally indicated)		12 Months
Spectacle Lenses		12 Months
Frame		12 Months
Contact Lens Evaluation, Fitting & Follow-Up Care		12 Months
Contact Lenses (in lieu of eyeglasses)		12 Months
Eyeglass Benefit - Frame	**Average Retail Value**	
Non-Collection Frame Allowance (Retail):	**Up to $150**	Up to $150 Plus a 20% discount on any overage[/1]
Davis Vision Frame Collection[/2] (in lieu of Allowance):		
Fashion level	Up to $125	Included
Designer level	Up to $175	Included
Premier level	Up to $225	$25 copayment
Eyeglass Benefit – Spectacle Lenses	**Average Retail Value**	**Member Charges**
Clear plastic single-vision, lined bifocal or trifocal lenses (any Rx)	$60-$120	Included
Oversize Lenses	$20	Included
Tinting of Plastic Lenses	$20	Included
Scratch-Resistant Coating	$25-$40	Included
Polycarbonate Lenses[/3]	$60-$75	$0 or $30
Ultraviolet Coating	$25-$30	$12
Standard Anti-Reflective (AR) Coating	$50-$70	$35
Premium AR Coating	$65-$90	$48
Ultra AR Coating	$100-$125	$60
Standard Progressive Lenses	$150-$195	$50
Premium Progressives (Varilux®, etc.)	$195-$300	$90
Intermediate-Vision Lenses	$150-$175	$30
High-Index Lenses	$90-$150	$55
Polarized Lenses	$95-$110	$75
Plastic Photosensitive Lenses	$95-$150	$65
Scratch Protection Plan: Single Vision | Multifocal Lenses		$20|$40
Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $230 Plus a 15% discount on any overage[/1]
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Included
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Up to $60 allowance Plus a 15% discount on any overage
Collection Contact Lenses[/2] (in lieu of Allowance): Materials - Disposable - Planned Replacement		 8 boxes /multi-packs 4 boxes /multi-packs
- Evaluation, Fitting & Follow-up Care		Included
Medically Necessary Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care		Included

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $75	Single Vision Lenses: $90	Trifocal Lenses: $200	Elective Contact Lenses: $290
Frame: $200	Bifocal/Progressive Lenses: $155	Lenticular Lenses: $200	Medically Necessary CL: $290

[/1] Additional discounts not applicable at Walmart or Sam's Club locations.

[/2] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

[/3] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

PARTICIPATING PROVIDER VISION PROGRAM

Arrangements have been made with Solstice Vision, through the Davis network to provide the following benefits to all eligible members and their eligible dependents:

- Comprehensive eye exam
- Choice of approximately 500 of the most fashionable frames on the market at no cost
- U.V., scratchcoating and tinting at no additional cost
- Contact lenses standard daily wear, full year supply
- A second pair of eyeglasses, single vision, or sunglasses, from a special selection of frames, at no additional cost.

The plan offers the services of a group of participating providers. By using one of these providers, you and your eligible dependents will be able to receive a vision examination and glasses with no out-of-pocket expense. The program offers a large selection of frames and lenses from which you may choose. If you decide **not** to choose from this selection, **you will have to pay the provider the difference.**

LIFE INSURANCE and ACCIDENTAL DEATH & DISMEMBERMENT PROGRAM

A Group Term Life and Accidental Death & Dismemberment Benefit is provided to all eligible members of the Employee Benefit Fund. Coverage may be available at your request when you retire. The premium is determined annually by the trustees. Please refer to the Schedule of Benefits Supplement for more details as well as to the booklet summary provided by the carrier.

NOTE: See website for the booklet/certificate which provides all the details of the Teachers and Administrators' Group Term Life and Accidental Death & Dismemberment Insurance Program.

COBRA - CONTINUATION OF COVERAGE

On April 7, 1986, a Federal law was enacted-Public Law 99-272, Title X - requiring that most employers sponsoring group dental & vision plans offer employees and their families the opportunity for a temporary extension of coverage - called continuation coverage - at group rates in certain instances where coverage under the plan would otherwise end.

You and your covered dependents have a right to choose this continuation coverage (for a maximum of 18 months) if you lose your coverage because of a reduction in your hours of employment or the termination of your employment, except for reasons of gross misconduct on your part.

A spouse of an employee covered by this plan has the right to choose continuation coverage for yourself (for a maximum of 36 months) if you lose coverage under this plan for any of the following reasons:

(1) the death of your spouse;
(2) divorce or legal separation from your spouse; or
(3) your spouse becomes eligible for Medicare.

A dependent child of an employee covered by this plan has the right to continuation coverage (for a maximum of 36 months) if coverage is lost for any of the following reasons:

(1) the death of the parent/employee;
(2) parent's divorce or legal separation;
(3) a parent becomes eligible for Medicare; or
(4) the dependent child ceases to be an eligible dependent.

In the event of a Chapter 1 Bankruptcy, certain retirees and their dependents also have rights of continuation.
Under the law, the employee or a family member has 60 days to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the plan.

Your employer has the responsibility to notify the plan administrator in the case of an employee's death, termination of employment or reduction in hours, or Medicare eligibility.

When the Chappaqua Congress of Teachers Benefit Fund is notified that one of these events has happened, you will be notified that you have the right to choose continuation coverage.
Under the law, you have 60 days from the day you would lose coverage to inform your plan administrator (whichever is appropriate) that you want continuation coverage.

If you do not choose continuation coverage, your benefits will end.

If you choose continuation coverage, your employer is required to offer you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

(1) your former employer no longer provides coverage to any of its employees;
(2) the premium for your continuation coverage is not paid;
(3) you become eligible for Medicare;
(4) you've reached the end of the 18, 29 or 36 month period;
(5) the date you become eligible for benefits under another group plan provided the plan does not exclude preexisting conditions from coverage;

(6) the date a former spouse or dependent child becomes eligible for coverage under another group program;

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay the required part of the premium which includes a 2% administration fee for your continuation coverage. The law also states that, at the end of the 18th month, 29th month or three-year continuation coverage period, your coverage will be terminated.

Continuance During Disability

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment (or, effective January 1, 1997, during the 60 day period thereafter). To benefit from this extension, you must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual also must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Any questions about this law should be addressed to the Plan Administrator. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify your Benefits Coordinator

FAMILY AND MEDICAL LEAVE ACT (FMLA)
as Federally Mandated

Family and Medical Leave

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) your coverage may be continued on the same basis as if you were an actively-at-work employee for up to 12

weeks during the 12 month period, as defined by your employer, for any of the following reasons:

(a) to care for your child after the birth or placement of a child with you for adoption or foster care, as long as such leave is completed within 12 months after the birth or placement of the child;
(b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
(c) for your own serious health condition.

In the event you and your spouse are both covered as employees of the School District, the continued coverage allowed under item (a) and (b) may not exceed a combined total of 12 weeks.

Conditions:

(a) If, on the day your coverage is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Coverage for you and any eligible dependents will begin in accordance with the terms of the policy. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.

(b) You are eligible to continue coverage under FMLA if:
  (1) you have worked for your employer for at least one year;
  (2) you have worked at least 1,250 hours over the previous 12 months;
  (3) your employer employs at least 50 employees within 75 miles from your worksite; and
  (4) you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.

(c) In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the policy during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the policy. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
(d) You and your dependents are subject to all conditions and limitations of the policy during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
(e) If requested by us, you or your employer must submit proof acceptable to Claims Administrator that your leave is in accordance with FMLA.
(f) This FMLA condition is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the policy following the day your FMLA continuation ends:

(g) FMLA continuation ends on the earliest of:

(1) the day your return to work;
(2) the day you notify your employer that you are not returning to work;
(3) the day your coverage would otherwise end under the policy;
(4) the day your coverage has been continued for 12 weeks.

Important Notice:

Contact your Benefits Coordinator in the school district office for additional information regarding FMLA.

GENERAL INFORMATION CONCERNING PLAN COVERAGE

The benefits provided by this Plan are for reimbursement of incurred expenses, and payment by the Plan will be made only for those costs actually incurred and paid for by the eligible Participant. Reimbursement will not be made for any amounts for which the Participant is not legally liable in the absence of coverage by this Plan.

APPEALS

In the event a part or all of a claim is denied due to the enforcement of the Plan document, you may appeal to the Claims Administrator. All appeals must be in writing and directed to our plan administrator. Please provide all information needed to support your appeal. The letter should be sent to the administrator so that it can be presented at the next scheduled meeting of the Trustees. Appeals must be received in writing no later than 60 days after you receive the determination in question.

RIGHT OF RECOVERY

A. Whenever we have made payments for Covered Services in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, irrespective of to whom paid, we have the right to recover the excess payment from one or more of the following: any person to or for whom such payments were made, any insurance companies or any other organization.

B. You, personally and on behalf of your enrolled family members will, upon request, execute and deliver such documents as may be required to recover excess payments. Your failure to comply will result in a withdrawal of benefits already provided or a denial of benefits requested.

C. In the event you are delinquent in the payment of your annual contribution to the Fund, we have the right to recover any payments made to you.

PLAN CANCELLATION OR TERMINATION

The Trustees intend to continue the benefits described in this booklet indefinitely. However, the Trustees reserve the right to change or discontinue the type and amounts of benefits offered by the Fund and the eligibility rules for coverage.

Benefits provided through the Fund and eligibility rules for active, retired, or disabled participants:

- are not guaranteed,
- may be changed or discontinued by the Board of Trustees,
- are subject to the rules and regulations adopted by the Board of Trustees,
- are subject to the Trust Agreement which establishes and governs the Fund operations, and
- are subject to the provisions of the group insurance policies purchased by the Trustees.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

TO: Participants in health plans sponsored by the Chappaqua Congress of Teachers Benefit Fund

FROM: Plan Administrator

The health plan options sponsored by the Chappaqua Congress of Teachers Benefit Fund (referred to this Notice as the "**Health Plan"** may use or disclose medical information about participants (employee and their covered dependents) as required for purposes of administering the Health Plans, such as for reviewing and paying claims, utilization review. Regardless of who handles medical information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, **"Plan"** to refer to each Health Plan sponsored by the Chappaqua Congress of Teachers Benefit Fund including any trustees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. Health Plan means, for purposes of this notice, medical, dental, vision, and other coverages that meet the definition of Health Plan container in HIPAA.

As required by Federal Law, this Notice is being provided to you to describe the Plan's health information privacy procedures and policies. It also provides details regarding certain rights you may have under Federal Law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. **This Notice is effective beginning April 14, 2003** and will remain in effect until it is revised.

If the Plan's health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will provide a new updated Privacy Notice. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information held by the Plan that includes identifying information about you (or your dependents). Such information, regardless of the form in which it is kept, is referred to in this Notice as **Protected Health Information** or **"PHI"**. For example, any health information that includes details such as your name, street address, a date of birth or social security number is PHI. However, information that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow the person who is reviewing that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and such information may be used for any purpose that is consistent with applicable law and with the Plan's policies and requirements.

How the Plan Uses or Discloses Protected Health Information

Protected Health information may be used or disclosed by the Plan as necessary for the operation of the Plan. Specifically, PHI may be used or disclosed for the following Plan purposes.

- **Treatment:** If a provider who is treating your requests, any part or all of your health care records that the Plan possesses, the Plan generally will provide the requested information.

- **Payment:** If the plan needs PHI to review a claim or to make a payment to a provider or for similar payment-related purposes, the Plan may use that information (or will request that information, if it does not already possess it) and will review the information for payment purposes.

- **Other Health Care Operations:** The Plan may also use PHI as needed for various purposes that are related to the operation of the plan. These purposes include utilization review programs, quality assurance review, contacting providers or participants regarding treatment alternatives, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan.

- **Use or Disclosure Required by Law:** To the extent that the Plan is legally required to provide Protected Health Information to a government agency or anyone else, it will do so. In such cases, the Plan will make reasonable efforts avoid disclosing more information that is required by applicable law.

- **Disclosure for Public Health Activities:** The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

The Plan may also disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDS), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products.

Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

- **Disclosures about victims of abuse, neglect or domestic violence:** (The following does not apply to disclosures regarding child abuse or neglect, which may be made only as provided under **Disclosure for public health activities).**

If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

- **Health Oversight Activities:** The Plan may disclose Protected Health Information to a health oversight agency (this includes Federal, State or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.

- **Disclosure for Judicial and Administrating Proceedings:** The Plan may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.

- **Disclosures for Law Enforcement Purposes:** The Plan may disclose Protected Health Information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.

- **Disclosures to Medical Examiners, Coroners and Funeral Directors Following Death:** The Plan may disclose Protected Health Information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

- **Disclosures for Organ, Eye or Tissue Donation Purposes:** The Plan may disclose Protected Health Information to organ procurement organization or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- **Disclosures to avert a serious threat to health or safety:** The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose Protected Health Information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement

authorities to identity or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.

- **Disclosures for Specialized Government Functions:** If certain conditions are met, the Plan may use and disclose the Protected Health Information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.

The Plan may also or disclose PHI to authorize federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by Federal law relating to those protective services.

- **Disclosures for Workers' Compensation Purposes:** The Plan may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Uses and Disclosures Not Mentioned Above: Authorization Require

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned above, except as specifically authorized by you. If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your **authorization**. You may complete an Authorization Form if you want the Plan to use or disclose health information to you, or to someone else at your request, for any reason.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

Your Health Information Rights

Under Federal Law, you have the following rights:

- **You may request restrictions with regard to certain types of uses and disclosures*:*** This includes the uses and disclosures described above for Treatment, Payment and other health plan operations purposes. If the Plan agrees to a restriction you request, it will abide by the terms of that restriction. However, under the law, *the Plan is not required to accept any restriction.* If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan, it may decline the request.
- **If PHI is being provided to you, you may request that the information be provided to you in a confidential manner:** This

right applies only if you inform the Plan in writing that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such requests as long as they are reasonable, but the Plan reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.

- **You may request access to certain medical records possessed by the Plan and you may inspect or copy those records:** This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage.
- **You may request that Protected Health Information Maintained by the Plan be amended:** If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide sufficient information to the Plan to establish that the originator of the information is not in a position to amend it.

The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.

If the Plan denies your request, you will have the opportunity to prepare a statement to be included with the health records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.

- **You have the right to receive details about certain non-routine disclosures of health information made by the Plan:** You may request an accounting of all disclosures of health information with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operation purposes, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made before April 14, 2003 or for any period earlier than 6 years from the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12-month period.

- **You have the right to request and receive a paper copy of the Privacy Notice:** If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one.

Health Information Complaint Procedures

If you believe your health information privacy rights have been violated, you may file a complaint with the Plan. To file a complaint, you should contact Fitzharris' Privacy Department, P.O. Box 9182, Farmingdale, NY 11735. In addition to your right to file a complaint with the Plan, if you feel your privacy rights have been violated, you may file a complaint with the U.S. Department of Health & Human Services. You will never be retaliated against in any way as a result of any complaint that you file.

CHAPPAQUA CONGRESS OF TEACHERS BENEFIT FUND

LEGAL SERVICE PLAN
January 2008

GROUP LEGAL SERVICES PLAN

COVERAGE:

The plan covers the plan member, spouse, children to the age of 19, living at home, or dependent children in school and not gainfully employed to age 25. The plan is limited to the practice of law in the States of New York, Connecticut and New Jersey and within a 50-mile radius of Chappaqua, New York.

INCLUDED SERVICES:

1. Consultation and Advice (in office or by phone)
    a. Any personal matter
    b. Any business matter

2. Simple Document Preparation or Review (personal non-business matters):
    a. Loan Agreements
    b. Contracts to buy or sell personal property, e.g.: automobiles
    c. Installment sale contract, e.g.: to purchase household furnishings
    d. Leases

3. Correspondence and Telephone Communication to Third Parties
   (personal non-business matters), e.g.:
    a. Property damages claims, e.g.: automobile accidents
    b. Consumer problems, e.g.: defective products or services
    c. Negotiation of debt repayment obligations
    d. Protection against improper debt collection practices
    e. Landlord/Tenant problems

4. Purchase and sale of house, condominium or cooperative apartment
   (Member's primary residence)

5. Simple Will for member and spouse

6. Living Will, Medical Care Proxy

7. General Power of Attorney

8. Initial appearance at Criminal and Family Court (Emergency night telephone number is provided below)

MATTERS NOT COVERED

1. Anything not specifically included in plan
2. Claims between members of the plan
3. Claims between the member, spouse, or dependent and the Trust Fund, the Association or the School District or arising under the Collective Bargaining Agreement
4. Matters currently with another attorney
5. Unmeritorious or spite claims
6. Litigation before any Court or Administrative Tribunal
7.

REDUCED FIXED FEE SCHEDULE FOR NON-INCLUDED SERVICES:

1. Purchase or sale of house, condominium or cooperative apartment (non-primary residence): $1000
2. Traffic Court matters: $150 per pre-trial Court appearance: trial by agreement
3. Administration or Probate of Estate: 2.5% of gross estate (minimum $1,500)
4. Name change: $750
5. Uncontested Adoption: $750
6. Uncontested Divorce or Uncontested Separation Agreement (excludes negotiation): $750
7. Uncontested Personal Bankruptcy: $2500
8. Personal injury actions: 25% contingency fee
9. Business and personal matters not set forth in the Fixed Fee Schedule: Fees shall be mutually agreed to by the attorney and client

NOTE: Court and filing fees or other disbursements are payable by the client.

HAROLD, SALANT, STRASSFIELD & SPIELBERG
81 Main Street
White Plains, New York 10601
Tel: (914) 683-2500 Ext. 310; Fax: (914) 683-1279
Email: charold@haroldsalant.com
Christopher Harold's Cell Telephone Number,
For Emergency Use Only:
Cell (914) 420-8636

CHAPPAQUA CONGRESS OF TEACHERS BENEFIT FUND

FINANCIAL COUNSELING PROGRAM

The Financial Counseling Program offers you and your family in person and/or telephonic access to a Certified Financial Planner® or Registered Investment Advisor from the NYSUT Member Benefits endorsed firm of Stacey Braun Associates Inc. This service is provided at **NO COST TO YOU**. The Chappaqua Congress of Teachers benefit Fund covers the entire cost of this service. ***Stacey Braun representatives are prohibited from soliciting investment and/or insurance products.***

Financial consultations are designed to address your specific financial questions and situations. Consultations can be in-person, over the phone or a combination of both. Meetings can be used to review your financial situation, address specific financial issues or questions, and identify other areas that may require attention. Consultations can take place at school locations, a NYSUT office or Stacey Braun's office in downtown Manhattan.

Any family member or significant other may attend a consultation with you.

Topics that can be Discussed with Planner (Among Others):

1. Pre- & Post-Retirement Planning
2. 403(b) & 457(b) Plan Advice
3. Pension Option Analysis
4. Mutual Fund Questions
5. Establishing Risk Tolerance
6. Asset Allocation
7. Mortgages & Refinancing
8. Debt Management
9. Savings
10. Cash Flow
11. Long-Term Care Insurance
12. Estate & Inheritance Planning
13. Survivorship Planning
14. Financial Advice relating to Divorce
15. Tax Planning
16. Life & Disability Insurance
17. Budgeting
18. IRA Rollovers
19. Social Security
20. Education Funding

21. Elder Care Analysis
22. General Financial Education

Other Features of the Program:
1. You can request assistance in choosing a 403(b) retirement savings program provider available through your employer. Likewise, you can get assistance on reviewing your investment selections offered by your current 403(b) provider.

2. Access to Stacey Braun's password-protected website and email helpdesk is also included in the program.

3. You can also request customized summaries and reports on financial issues reviewed during your consultation. These summaries may provide a detailed review and recommendation for your current situation. Reports may be available upon request following completion of a consultation with a Stacey Braun Planner.

Toll Free Phone Number: 888-949-1925

Website: www.staceybraun.com
User ID: chappaqua
Password: money

FITZHARRIS BENEFITS ADMINISTRATORS
814 Fulton Street (RT.109)
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Farmingdale, NY 11735-9182
(516) 777-2244
1-800-321-1336