GREENBURGH TEACHERS FEDERATION WELFARE FUND

MEMBER BENEFITS BOOKLET

July 1, 2016

Greenburgh Teachers Federation Welfare Fund
595 West Hartsdale Avenue, Suite 105
White Plains, New York 10607
www.gtfunion.com

BOARD OF TRUSTEES

Tom Tokarski
Neil Dahan
Laura Roth-Marino
Judie Mirra
Lynette Waterhouse

COUNSEL

Mirkin & Gordon, P.C.

AUDITORS

Buchbinder, Tunick & Company

THIRD-PARTY ADMINISTRATOR

Preferred Group Plans, Inc.

July 1, 2016

Dear Member:

The Trustees are pleased to provide you with this Comprehensive Benefits Booklet, which describes your benefits through the Greenburgh Teachers Federation Welfare Fund, as well as details of enrollment, eligibility, coverage for dependents, and other general information concerning Fund procedures.

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

Yours truly,

Board of Trustees

Tom Tokarski
Neil Dahan
Laura Roth-Marino
Judie Mirra
Lynette Waterhouse

TABLE OF CONTENTS

GENERAL INFORMATION

FUND INFORMATION

The Greenburgh Teachers Federation Welfare Fund (hereinafter referred to as the "Fund"), is a legal entity separate and distinct from the Greenburgh Teachers Federation Local 1788 (hereinafter referred to as the "Union"), and was established as a result of collective bargaining between the Greenburgh Central School District, (hereinafter referred to as the "District") and the Union. The Fund provides supplemental health-related and other benefits to its members and eligible dependents. Contributions to the Fund are predicated on the amount stipulated in the collective bargaining agreement(s) between the Union and the District and other pertinent documents.

The primary source of contributions to the Fund is the employer, the District. Contributions are remitted on behalf of each member of the bargaining unit represented by the Union who works half time or more as defined in the collective bargaining agreement(s) between the Union and the District. Contributions are used to provide benefits for the covered members and their eligible dependents and to finance the cost of administration of the Fund.

The Fund is governed by a Board of Trustees comprised of five members all of whom are appointed by the Executive Council of the Union. The current members of the Board of Trustees are listed in the beginning of this booklet.

The Board of Trustees has retained Third Party Administrator(s), whose primary functions are the processing of claims and assisting in the day to day administrative operations of the Fund.

ENROLLMENT REQUIRED FOR BENEFITS

In order to receive benefits from the Fund, new members must complete an Enrollment Form, which may be obtained from a Trustee or downloaded from the Greenburgh Teachers Federation website www.gtfunion.com.

A new bargaining unit member and his/her eligible dependent(s) will be first eligible for benefits as of the bargaining unit member's first day of employment with the District provided they have enrolled; however, no benefits will be paid to the new bargaining unit member until November 1st. For example, if your first day of employment was July 1st, you and your eligible dependent(s) will be eligible for benefits as of that day, but will not be paid for any claim you have incurred until November 1st.

It is important that you notify the Fund, in writing, of any changes in your marital or family status and any change of your address. **Payment of benefits can be put in jeopardy if the member fails to notify the Fund of a subsequent change in marital status, change of dependent status or address, or neglects to confirm college-attendance status of a dependent child of their household.**

HOW TO DECLINE DENTAL AND OPTICAL COVERAGE

As required by the Patient Protection and Affordable Care Act, actively employed members may decline coverage of Welfare Fund dental and/or vision benefits for themselves and/or any enrolled dependents at any time by completing a Declination of Coverage form, which can be obtained by contacting the Fund office.

Since Welfare Fund benefits for actively employed members are funded exclusively by collectively bargained employer contributions, you will not receive a rebate or any other compensation if you decline dental and/or vision benefits.

ELIGIBILITY

COVERED MEMBER

In order to be eligible for benefits through the Fund, you must enroll as described on page 1 of this booklet. Covered members include each member of the bargaining unit represented by the Greenburgh Teachers Federation Local 1788 who works half time or more as defined in the collective bargaining agreement(s) between the Union and the District, employees of the District in the Administrators' Unit and Department Chairman's' Unit for whom equal contributions are paid by the District as those paid on behalf of teachers, and employees in other bargaining units and non-bargaining units, whom the Trustees may determine in their sole discretion, are eligible to participate in the Fund.

A member is entitled to benefits as long as the member is on active payroll status. Active payroll status means the period for which contributions are required to be paid on a member's behalf by the District.

Your eligibility for Fund benefits coverage will end when the first of the following events occurs:

- You are no longer eligible for coverage, as defined in this booklet, or
- Contributions made by the District on your behalf, or due from you, stop.

ELIGIBLE DEPENDENTS

Coverage for eligible dependents will begin:

a) On your first day of active employment, provided you enroll your eligible dependent(s) and the appropriate form for payroll deduction is completed and submitted by you to the Fund; however, no benefits will be paid to an eligible dependent until November 1st. For example, if your first day of employment was July 1st, your eligible dependent(s) will be eligible for benefits as of that day, but will not be paid for any claim you have incurred until November 1st, or

b) For new dependents, once the member's new dependent(s) are enrolled, subject to enrollment, your eligible dependents will receive certain benefits outlined in this booklet. Eligible dependents include:

- Your spouse to whom you are legally married;
- Your domestic partner
    - who is eighteen years of age or older;
    - who is not married or related by blood in a manner that would bar marriage in New York State;
    - who has an exclusive mutual, close and committed personal relationship with the member;
    - who lives with the member and has been living with same on a continuous basis for one year and you are able to provide proof of residency and financial interdependence[#];
    - who has been enrolled as a domestic partner by the member; and
    - has not terminated the partnership.

[#] *Evidence of financial interdependence is not required if the member has received, and provides the Fund with a copy of, a certificate of domestic partnership issued by the New York State Empire Plan or from any municipality which provides for domestic partner registration.*

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health-related benefits is treated as income to the covered member/employee, for tax purposes

when a person who is not a qualified dependent under Federal IRS rules, is covered under the Fund. Please ask your tax consultant how enrolling your domestic partner will affect your taxes.

- Your unmarried dependent children until the end of the month in which they reach their 19th birthday. Dependent children are your natural children, stepchildren, legally adopted children, including children in a waiting period prior to finalization of adoption, and any other children related to you by blood or marriage who are living in a regular parent-child relationship with you and are chiefly dependent upon you for financial support and maintenance. **To establish the eligibility of a stepchild or any other child related to you by blood or marriage, a member must submit an affidavit verifying that said child resides full-time with the member and proof of financial dependency as shown by income tax returns.**

- Unmarried dependent children who are full-time students at an accredited educational institution are covered by the Fund until they graduate, but in no event later than their 24th birthday. An unmarried child who is a full-time student will be covered up to the last day of the calendar year in which they graduate or reach age 24, whichever comes first. A full-time student means he/she is enrolled for 12 undergraduate credit hours or 6 graduate credit hours per semester. A Student Verification Form must be completed and submitted to the Fund before a claim can be honored. This form must be completed each semester and is available from The Preferred Group, a Trustee, or the College they are attending.

- Your unmarried children, regardless of age, who are incapable of self-sustaining employment by reason of mental or physical handicap and become so prior to their attaining age 19 and further provided that such children reside with a covered member and are wholly dependent on the covered member for support. You must submit proof of your dependent child's incapacity to the Fund within 31 days after he or she attains the age at which his or her coverage would otherwise terminate or within 31 days after you are notified of his or her ineligibility, whichever is later. Proof of the continued existence of such incapacity shall be furnished to the Fund from time to time at its request.

NON-DUPLICATION OF BENEFITS

Under this rule a member cannot be covered both as an employee and as a dependent at the same time. Therefore, if your spouse/domestic partner also works for the District or any other employer participating in the Fund:

a) Each must enroll separately, or
b) Only one may enroll as the dependent of the other.

If you enroll separately, one may not cover the other as a dependent, and all children must be enrolled with the same parent.

COORDINATION OF BENEFITS

In the event that a person covered by the Fund is covered under another group health 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.

a) The plan of the parent with custody pays first and the plan of the parent without custody pays second.
b) If the parent with custody has remarried the order is:
    1) The plan of the parent with custody pays first.
    2) Next, the plan of the step-parent pays.
    3) The plan of the parent without custody pays last.

If there is a court decree, which states that one parent is responsible for the child's health care expenses, the plan of that parent will pay first. That court decree will supersede any order stated above.

4. If a person is covered under more than one plan, the plan that he or she was under for the longer time period 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.

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 in its sole discretion. 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/or your dependents' coverage will stop on the earliest of the following dates:

- When the Fund is terminated.
- When you are no longer eligible.
- 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 sole 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 and otherwise exercise their sole prudent discretion at any time without legal right or recourse by a member or any other person.

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

The Fund has the right to recoup overpayments as a result of 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.

RIGHT TO APPEAL

The benefits provided by this Fund may be changed by the Board of Trustees in their sole and absolute discretion. 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 may request a review of action by submitting notice in writing to the Board of Trustees within 60 days after the action of the Fund Office at the following address:

Greenburgh Teachers Federation Welfare Fund
595 West Hartsdale Avenue, Suite 105
White Plains, New York 10607

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:

a) 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;

b) 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

c) 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.

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:

a) Surviving spouse/domestic partner;
b) If no surviving spouse/domestic partner, to the surviving children equally, or
c) If no surviving children, to the covered member's estate.

NOTICE OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the Greenburgh Teachers Federation Welfare 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 is distributed to all new members upon enrollment, a copy of which is available from The Preferred Group. 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.

CONTINUATION OF COVERAGE

COBRA CONTINUATION OF COVERAGE

Federal law requires that most group health plans (including the Greenburgh Federation of Teachers Welfare Fund, the "Fund") give employees (known as "members" in the case of the Fund) and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan (in this case, the Fund's plan of benefits under which the individual was covered). Depending on the type of qualifying event, "qualified beneficiaries" can include the employee/member covered under the Fund's plan, the covered employee's/member's spouse/domestic partner, and the dependent children of the covered employee/member.

Continuation coverage is the same coverage that the Fund's plan gives to other members or eligible dependents who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other members or eligible dependents covered under the Fund's plan. **Continuation coverage only applies to the Fund's dental and vision benefits programs.**

The following language is required by the federal health care law. The Fund cannot represent whether or not dental and/or vision only coverage is available through the health care exchanges.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Some General Questions and Answers

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

HOW LONG WILL CONTINUATION COVERAGE LAST?

In the case of a loss of Fund coverage due to end of employment or reduction in hours of employment with the Greenburgh Central School District, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to a member's/ employee's death, divorce or legal separation, the member's/employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Fund's plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the member's/employee's hours of employment with the Greenburgh Central School District, and the member/employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the member/employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium for continuation coverage is not paid to the Fund in full and on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Fund ceases to provide any health related benefits to its members.

Continuation coverage may also be terminated for any reason that the Fund would terminate the coverage of a member who is not receiving continuation coverage.

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage from the Fund, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Fund's Director of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide the Fund's Director with a copy of an SSA disability determination letter within 60 days of the determination in order to extend the period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Fund's Director of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered member/employee, divorce or separation from the covered member/employee, the covered member's/employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund's plan. These

events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Fund's plan if the first qualifying event had not occurred. You must notify the Fund's Director within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Fund's **Continuation Coverage Election Form** and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the member's/employee's spouse may elect continuation coverage even if the member/employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The member/employee or the member's/employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your Fund health-related benefits coverage may affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Fund's health-related benefits coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the Fund for coverage of a similarly situated Fund member or eligible dependent who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

For more information

If you have any questions concerning COBRA continuation coverage, you should contact The Preferred Group.

For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) entitles eligible employees of the District with up to twelve (12) weeks of family leave in a twelve (12) month period to care for a dependent child, covered family members or for the serious illness of the employee. If you take a FMLA leave, the District must continue to contribute to the Fund on your behalf. If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation of coverage. Upon submission by the District to the Fund of documentation verifying your FMLA status, the Fund will provide benefits during the FMLA period.

Some General Questions and Answers

What is the Fund?

The Fund was established to provide certain benefits to supplement the District's basic health plan. It was created as a result of Collective Bargaining between the Greenburgh Teachers Federation and the Greenburgh Central School District. Employer contributions are predicated on the amount stipulated in the current Collective Bargaining Agreements and are provided at the annual rates, prorated monthly, on behalf of each covered member. Members, other than COBRA members, do not make contributions to the Fund.

Who administers the Fund?

A Board of Trustees administers the Fund. It consists of five persons designated by the Greenburgh Teachers Federation. Current members of the Board of Trustees are listed in the beginning of this booklet and can be communicated with in writing at the Fund office. The Board of Trustees governs the Welfare Fund in accordance with an Agreement and Declaration of Trust. The Board of Trustees retains third-party administrator(s) which are responsible for the day-to-day operation of the Fund, including the determination of eligibility and the processing of claims.

Do the contributions to the Fund become part of the general treasury of the union?

No. The Greenburgh Teachers Federation and the Greenburgh Teachers Federation Welfare Fund are **two (2)** distinct and separate legal entities. Their resources are not commingled.

What becomes of the contributions that the District makes to the Greenburgh Teachers Federation Welfare Fund?

Under the Agreement and Declaration of Trust, contributions to the Welfare Fund are used to provide benefits for covered members and their families and to finance the cost of administration.

Does the Greenburgh Teachers Federation Welfare Fund operate under ERISA?

No. The Fund is not subject to the provisions of the Employees Retirement Income Security Act of 1974 (ERISA).

Does the Greenburgh Teachers Federation Welfare Fund Operate under the Supervision of the New York State Insurance Department?

No. The Fund is not within the jurisdiction of the New York State Insurance Department as it is a unilaterally operated trust fund, administered by union trustees only.

WHERE TO FIND CLAIM FORMS

Dental and Vision claim forms are located on the Union website, a building representative or Preferred Group Plans, Inc., our plan administrator.

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 180 days of service. 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 payment voucher 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 their payment voucher to the claim you are filing through our plan. For additional information regarding duplicate benefits refer to page 4.

- Attach provider's itemized bill(s) or have the provider complete his or her portion of the form or have your provider send the claim in. If it is a dental claim coming directly from the provider a standard ADA form used by the provider is all that is needed as long as both the provider and patient have signed it.

- Completed forms can be mailed, faxed or emailed to the Claims Administrator. Preferred Group Plans, Inc. Benefits Administrators, P.O. Box 15136, Albany, New York 12212-5136, fax 518-641-0325 or email thru the secure web portal at www.thepreferredgroup.com.

- Questions regarding coverage should be directed to Preferred Group Plans, Inc. Benefits Administrators at 866-989-8997 or 518-641-0321.

COMMON CLAIM PROBLEMS

- Incomplete information regarding whether you or your spouse has other group insurance coverage, and if so, name or group, name of insurance company, address, policy number, etc. If there is other group coverage, send a copy of the benefit payment record 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 180 days of date of service.
- Failure by dentist to provide age of prior placement when seeking replacement of crown, denture or fixed bridgework.

MAY WE REQUIRE ADDITIONAL PROOF OF CLAIM?

1) Yes. Before paying benefits, we can require the following:
2) A dental chart showing work done before the treatment for which claim is made.
3) X-rays, lab or hospital records.
4) Cast molds or other evidence of the dental condition of treatment.
5) 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 an amount of benefits up to 100% of the scheduled allowance.

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.**

DEFINITIONS

Allowable Charge

A charge which is included in the list of covered expenses and does not exceed the scheduled allowance 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.

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.

Family Member

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

Incurred Expense

Except as noted below, an expense is deemed to be incurred on the date a service is rendered or a supply is furnished.

EXCEPTIONS

- 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.

Lifetime Maximum Benefit

The total amount of benefits which will be available to a Covered Person during his lifetime.

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**

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 dental services he proposes to render to a **Covered Person;** and
- shows his 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?

The fund will pay a Covered Expense up to the allowable charge for Preventive, Diagnostic, Fillings, Prosthetic Restorative and Orthodontic services.

IS THERE A MAXIMUM BENEFIT?

The maximum the fund will pay for all Covered Expenses, including orthodontia, during a benefit year is indicated on the Schedule of Benefits Supplement available from a trustee, the website or Preferred Group.

SHOULD BENEFITS BE DETERMINED BEFORE TREATMENT STARTS?

One of the advantages of the fund's 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 Predetermination 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, Preferred Group Plans, P.O. Box 15136, Albany, N.Y. 12212-

5136. The fund's 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, the fund 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 Claim Administrator. The Claims Administrator will advise you and your dentist of the approved covered dental procedures.

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 for Preventive and Diagnostic Services Preventive Services

- Cleaning and scaling teeth (prophylaxis) twice each Benefit Year.
- Fluoride treatments for a child's teeth twice each Benefit Year, limited to children under age 16.
- Space maintainers and their fitting. For children only.
- Sealants - limited to permanent molar teeth, one per tooth in any 36-month period to age 16.

Diagnostic Services

- Routine oral exams twice each Benefit Year.
- Emergency visits are covered by the Plan even if no actual dental treatment is provided during the same day. No more than two (2) emergency treatments will be covered in any one-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 one 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.

Periodontal Services

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

6) Medication - The plan covers charges for injectable antibiotics administered by a dentist or physician for covered dental care.

Fillings

- Silver (amalgam) and composite fillings. Fillings involving the same surfaces are not covered within 2 years of date of first filling.

Prosthetic Services and Supplies (Repairs and Rebasing)

- 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 fix bridge work or partial dentures to replace missing natural teeth.
- The teeth that are being replaced must be lost while the person is covered.

Covered Charges for 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 and gold fillings are covered only if the old crown or filling 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.

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 available on the web, from a trustee or the Preferred Group (866-989-8997).**

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 or dependent 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:
5) 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.
6) Replacement of existing dentures or fixed bridgework, or addition of teeth to existing dentures or fixed bridgework, unless;
    a) the replacement or addition is needed to replace at least one natural tooth extracted while covered under the Dental Plan; or
    b) the existing denture or fixed bridgework was installed at least five years prior to the replacement and cannot be made serviceable.
7) Replacement of lost or stolen dentures or fixed bridgework.
8) 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.

9) MISCELLANEOUS SERVICES—Charges for oral hygiene instruction, plaque control, dietary instructions.
10) The benefit fund plan document indicates time restrictions before certain expenses are covered. The Trust will not waive these restrictions.
11) Any service or supply which is not customarily performed, not reasonably necessary for dental care or treatment, or is experimental in nature.
12) 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.

13) 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.

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.

OPTICAL EXPENSE BENEFIT

The Maximum allotment a member and his/her family have is $500 total per plan year. This can be used to for eye exam, glasses, contact lenses or sunglasses (Lasik surgery is not included in this coverage). You can purchase your optical needs anywhere you decide and submit a claim form with the bill.

Raymond Opticians has agreed to be a vision provider offering special benefits to all Greenburgh Welfare Fund members. There will be no paperwork Raymond will submit the claim for payment. You can email Raymond Opticians for information at info@raymondopticians.com be sure to identify yourself as a Greenburgh Teachers Federation Welfare Fund member.

You may also contact our Claim Administrator, Preferred Group Plans, Inc. @ 866-989-8997.

LIFE INSURANCE PROGRAM

All members of the Welfare Trust Fund, with the exception of administrators, are automatically covered by $100,000 through The Hartford group term life insurance. A special advantage of this policy is that it is portable. This means that your Life Insurance coverage is available to you when you leave the district employ, whether or not you choose to remain a member of the Welfare Fund. You will need to request a conversion form from Preferred Group Plans, Inc. And submit to the carrier for approval within 31 days of your leaving. You will have to pay the premium required. See your certificate of life insurance for all details regarding the policy. A copy can be found on the website www.gtfunion.com.

Be sure to keep your beneficiary information current.

If a claim needs to be submitted for the death benefit contact the Trust administrator, Preferred Group Plans for information and necessary paperwork.

LONG TERM DISABILITY

Coverage is through The Hartford. It should be noted there is a 180 day waiting period before a claim will be processed. For complete information regarding this plan check your certificate of coverage which can be found on the website www.gtfunion.com, or call Preferred Group Plans.

LEGAL PLAN

The fund will reimburse the member a maximum of $250 for any legal expense incurred during the plan year. This benefit may be used to pay a premium the employee has purchased from NYSUT or any other organization.

THIS PAGE INTENTIONALLY LEFT BLANK

THIS PAGE INTENTIONALLY LEFT BLANK

PREFERRED GROUP PLANS, INC.
CUSTOM BENEFIT ADMINISTRATORS
P.O. BOX 15136
ALBANY, NY 12212-5136
www.ThePreferredGroup.com
(866) 989-8997
FAX: (866) 539-1394