

WHITE PLAINS TEACHERS ASSOCIATION
WELFARE TRUST FUND

Revised July 1, 2025

Plan Year: January 1st through December 31st.

Eligible Members: All Active Teachers who work at least 17.5 hours per week and are members of the White Plains Teachers Association Welfare Trust Fund.

All dependents as defined.

Retirees covered under “The Severance Plan”.

Plan Administrator: Administrative Services Only (ASO)
303 Merrick Road
Lynbrook, NY 11563
Phone: 800-537-1238
Fax: 877-414-4069
Website: www.asonet.com

Claim status and claim Explanation of Benefits (EOB)
can be obtained through Administrative Services Only website.

For more details on all benefits consult Administrative Services Only

This booklet supercedes any document previously issued concerning these benefits.

NOTES

DENTAL PLAN

DENTAL PLAN

Annual Schedule of Benefits

Maximum Dental Benefit: \$3,000.00 per member per Plan year.
\$5,000.00 per family per Plan year.

Maximum Orthodontic Benefit – Lifetime: \$3,000.00 per person

Maximum TMJ Benefit: \$500.00 (This is subject to the Maximum Dental Benefit.)

Annual Deductible: \$100.00 (Per Person)

The Deductible does not apply to Diagnostic, Preventive and Orthodontic Charges.

Carryover Deductible Provision: Covered Dental Expenses applied to your individual or family deductibles during October, November or December will also be applied to your deductible(s) for the next Plan year.

Dental Co-Insurance Rates: Diagnostic & Preventive Charges – 100% of Plan Fee Schedule

Basic Charges – 100% of Plan Fee Schedule

Major Charges: - 100% of Plan Fee Schedule

Orthodontic Charges: - 100% of Plan Fee Schedule

Dental Preferred Provider Network: Dental Providers who have agreed to accept the Plan as payment in full in most instances. A list of these providers may be obtained from the WPTA office.

For more details consult the Plan Administrators, Administrative Solutions Only.

When Your Coverage Begins

You will be eligible for coverage the first day of the calendar month following the date of initial employment.

If you enroll for coverage on or before the day you become eligible, you will be covered on the day you become eligible.

If you enroll for coverage within thirty days after the day you become eligible, you will be covered on the day you enroll.

When Your Dependents' Coverage Begins

Dependent means:

- a) An employee's spouse whether married or legally separated from the employee.
- b) Qualified Domestic Partner.
- c) Each of your unmarried children. The term "children" also includes any other single child if that child lives in your household in a parent-child relationship and is dependent on you for support.

Each child must be under age nineteen (19), or a full-time student under age twenty-five (25). Full-time student is defined as carrying at least 12 credits at an accredited institution of higher learning. Documentation per semester is required for verification.

If your child is mentally ill, developmentally disabled or mentally challenged or has a physical handicap when coverage would end due to the child's age, coverage may be continued. Ask your Fund Trustee within thirty-one days of the date the coverage ends for details and forms.

Each person who is your dependent on the day you become eligible for coverage is eligible on that day. Each other person is eligible on the day that person becomes your dependent.

If any of your dependents are eligible under this plan for coverage as an employee, that person is not eligible for coverage as a dependent. If both you and your spouse (whether married, legally separated or divorced) are covered under this plan as employees, only one parent will be permitted to enroll eligible dependents.

You should enroll your dependents promptly.

Your dependents will not be covered before the day your coverage begins.

Treatment Plans

If Covered Dental Charges for any course of treatment are expected to be more than \$300 and you wish an estimate of any benefits that would be payable, you may have the provider submit a treatment plan. This plan is a written report/claim made by the provider giving the results of an exam of the covered person and the suggested treatment.

The estimate is based on dental necessity only and does not take into account any deductibles and maximums or late enrollment penalties that may apply. If you are a

late enrollee you are subject to your plans penalty regardless of any pre-estimate you may receive.

The Maximum Dental Benefit that will be paid for a covered person in a calendar year is shown in the **Annual Schedule of Benefits**.

The Maximum Orthodontic Benefit that will be paid in the lifetime of a covered person for orthodontic treatment, including diagnosis, evaluation and pre-care, is shown in the **Annual Schedule of Benefits**.

Note: A temporary dental service will be considered an integral part of the final dental service rather than a separate service.

Covered Expenses

The Plan covers the following services and supplies, for which a charge is made by a provider, that are required in connection with the dental care and treatment of any disease, defect or accidental injury.

A. Preventive Treatment (100% Plan Fee Schedule)

- 1) Cleaning of teeth (prophylaxis) is covered twice during each plan year.
- 2) Fluoride treatments will be covered twice each plan year for members and each covered dependent.
- 3) Space maintainers.
- 4) Sealants to age 15.

B. Emergency Treatment (100% of Plan Fee Schedule)

Emergency visits are covered by the Plan even if no actual dental treatment is provided the same day. No more than two (2) emergency treatments will be covered in any one plan year.

C. Diagnostic Services (100% of Plan Fee Schedule)

The Plan covers oral examinations, X-rays and laboratory tests that may be necessary to diagnose a specific symptom.

The Plan will cover two series of Bitewing X-rays per plan year.

However, a full mouth x-ray of all teeth taken as part of a general examination is covered once in 36 months. Oral exams are covered twice per plan year.

D. Oral Surgery/Extractions (100% of Plan Fee Schedule)

The Plan covers all extractions and/or necessary oral surgery including fractures and dislocations. Allowances for extractions and oral surgery procedures include routine postoperative care.

E. Fillings (100% of Plan Fee Schedule)

The Plan covers all fillings that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury. This includes all silver (amalgam) and composite fillings.

F. Periodontal Services (100% of Plan Fee Schedule)

The Plan covers necessary periodontic treatment of the gums and supporting structure of the teeth. Periodontal maintenance and periodontal surgery will be covered as preventive care.

NOTE: If more than one periodontal surgical service is performed per quadrant, only the most inclusive surgical service performed will be considered. Also, Osseous surgery will not be covered within five years of the last treatment.

G. Root Canal Therapy (100% of Plan Fee Schedule)

The Plan covers root canal and other endodontic treatment. All services provided that are normally associated with root canal therapy are included in the scheduled fee.

H. Crowns/Onlays and Inlays (100% of Plan Fee Schedule)

Crowns that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury and cannot be reconstructed by a filling or other material are covered. This includes gold, porcelain and plastic restorations. Gold onlays and inlays are also covered if the tooth cannot be reconstructed by a filling or other material. Replacement crowns and onlays or inlays are not covered within five years of prior placement.

I. Prosthetics (100% of Plan Fee Schedule)

The Plan covers prosthetic appliances (full denture, partial removable or fixed bridgework). The Plan also covers dentures or fixed bridges that replace an existing appliance, if the prior appliance is more than 5 years old and cannot be made satisfactory. When teeth are being replaced within the same arch, but not within the same quadrant, an allowance for a partial will be made and not for fixed bridgework. The Plan also includes benefits for repairing damaged dentures or adding teeth to existing dentures or rebasing of an old denture. The plan will not cover replacement of prosthetic appliances in less than five years.

J. Implants (100% of Plan Fee Schedule)

Implants which are not of an experimental nature are a covered service. The crown will be paid in addition to the implant.

K. Orthodontic Services (100% of Plan Fee Schedule)

Charges for Orthodontic appliances and treatment are covered if incurred during a course of orthodontic treatment. These charges include: Preliminary study including cephalometric radiographs, diagnostic casts and treatment plan, all active and passive appliances and active treatment per month. There is a maximum life-time orthodontic benefit. See the **Annual Schedule of Benefits.**

L. Second Opinion Benefit

If you or a covered dependent need a root canal, periodontia, oral surgery, orthodontia, bridges, dentures, crowns or other major services, you may want to get a Second Opinion. The Provider who is performing the second opinion can bill you for a Professional Consultation. The maximum benefit you can receive for the consultation is \$75. In the event the Provider's charge is less than \$75 then you will receive that amount. You and your covered dependents will be entitled to one second opinion benefit per plan year for one of the conditions/treatments listed above. No deductible will be applied to this service. In order to receive your benefit the following provisions apply:

- 1) The provider must not be the person who is performing the actual work.
- 2) You must have the Provider write on your claim form "for second opinion purposes only" when they submit for the Professional Consultation.

When Is A Charge Incurred?

If the work is performed on a date other than the date the work was recommended or considered necessary, the work will be considered to begin on the date the actual performance of the work begins.

A charge is incurred on:

- a) the date the impression is taken, in the case of dentures or fixed bridges.
- b) the date the preparation of the tooth is begun, in the case of crown work.
- c) the date the work on the tooth is begun, in the case of root canal therapy.
- d) the date the work is done, in the case of any other work.

No benefits will be paid for any charges incurred for dental work more than sixty days after the date the person's coverage ends.

Plan Exclusions

Covered Dental Charges do not include charges for services and supplies:

- a) that are a result of an injury arising out of or in the course of employment which is compensable under any Workers' Compensation or Occupational Diseases Act or Law;
- b) not ordered by a dentist;
- c) due to loss or theft of dentures or bridges;
- d) which a covered person would not legally have to pay if there were no coverage;
- e) due to war, if declared or not;
- f) due to intentionally self-inflicted injury or sickness;
- g) for a congenital or developmental malformation;
- h) for cosmetic reasons, unless needed as a result of injury. Facings on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic;

- i) for replacing of a bridge or denture within five years after the date of its original installation unless, (a) one or more teeth is such replaced or added to the device; or (b) the device is 5 years old and unserviceable; or (c) the complete denture is temporary and cannot be made permanent. In such case the permanent denture must be installed within 12 months from the date the temporary one was installed;
- j) for replacing of bridge or denture which, meets or can be made to meet commonly held dental standards of functional acceptability;
- k) for appliances or restorations, whose primary purpose is to alter vertical dimension, restore occlusion, stabilize periodontically involved teeth or replace tooth structure lost as a result of abrasion or attrition;
- l) for the initial placement of denture or bridge if it involves replacement of one or more natural teeth lost prior to a covered person becoming insured. This limitation does not apply if the denture or bridge also includes replacement of a natural tooth, which is extracted while the covered person is insured under this plan;
- m) for these items:
 - 1) Myofunctional therapy or correction of harmful habits
 - 2) Oral Hygiene, dietary, plaque control and other educational programs
 - 3) Duplicate prosthetic appliances, bite registrations
 - 4) Repairing orthodontic appliances

Dental Preferred Provider Network

The Dental Preferred Providers Network is a group of providers who have agreed to take the White Plains Teachers Association Dental Plan as payment in full (except for Orthodontia, where a discount will be taken).

Once you have used your entire annual dental maximum you will be billed and responsible for any charges. The same is true for any services not covered by your plan. The provider will receive the payments directly.

Identify yourself as a member of the White Plains Teachers Association when making appointments for you and your dependents.

A list of these dental providers can be obtained at the WPTA office.

VISION CARE PLAN

VISION CARE PROGRAM

Annual Schedule of Benefits

Annual Vision Benefit: **One examination and one pair of glasses or contact lenses at no charge through a Participating Provider.**

**Non-Participating
Provider Schedule of
Benefits:**

Eye Examination	\$37.00
Eye Examination, single vision lenses and frames	\$110.00
Eye Examination, bi-focal lenses and frames	\$147.00
Eye Examination, tri-focal lenses and frames	\$193.00
Eye Examination, contact lenses or any type of lenses not listed	\$193.00

You are responsible for a \$25.00 co-pay for contact lenses.

**Participating Vision
Providers:**

Davis Vision Providers – lists can be obtained at www.davisvision.com or (800) 999-5431. When making an appointment identify yourself as a member of White Plains Teachers Association.

Raymond Opticians – a list of offices can be obtained from the WPTA office. When making an appointment identify yourself as a member of White Plains Teachers Association. (Offers second pair of glasses free.)

If you use a participating provider and choose from the plan frames, etc., the claims administrator will pay the providers directly and you will not be billed, unless you have chosen non-plan services.

Covered Services

Eye Examination - Check of principal vision functions, ability and condition of vision. If a medical diagnosis exists, the claim should be filed with your major medical insurance carrier.

Glasses and/or contact lenses are covered if a visual deficiency exists.

The Plan will allow maximum amounts per benefit per individual to be used for any eye examination, glasses and /or contacts. **Please see the Annual Schedule of Benefits for this maximum amount.**

These benefits for you and your dependents are available once per plan year. Members and dependents using disposable contact lenses are advised to utilize the maximum benefit by purchasing the full amount of lenses at one time, or accumulating the expenses until you have reached the maximum benefit before filing for reimbursement. **Please see the Annual Schedule of Benefits for current benefit amounts.**

Participating Provider Vision Program

The Plan offers the service of a group of participating providers through Davis Vision and Raymond Opticians. By using one of these providers you and your eligible dependents will be able to receive a vision examination and glasses/contacts with little or no out-of-pocket expense. The program offers a selection of frames and lenses from which you may choose. If you decide not to purchase frames or lenses through the program, **you will have to pay the optometrist's charges for the frames and lenses you choose.** However, the claim will be submitted to your vision plan and you will be reimbursed up to the plan's allowance.

To utilize the Participating Provider Program you need only make an appointment with a Davis Vision Provider or Raymond Opticians and identify yourself as a member of the White Plains Teachers Association.

Non-Participating Provider

You may also use any vision provider of your choice. You will be reimbursed for the benefits used. **See the Annual Schedule of Benefits for these amounts.**

GROUP LIFE INSURANCE PROGRAM

GROUP LIFE INSURANCE PROGRAM

The Fund provides one (1) Life/Accidental Death and Dismemberment policy of \$50,000.00. If you are still actively employed at age 65, the amounts reduce to \$32,500.00, at age 70 the amounts reduce to \$21,500.00 and at age 75 the amounts reduce to \$14,000.00.

When retired (Life Insurance Only), the amount of Life Insurance at retirement will reduce to \$25,000.00 when you reach age 65 and will reduce to \$2,000.00 when you reach age 70.

RETIREE SEVERANCE PLAN

RETIREE SEVERANCE PLAN

The Severance Plan covers benefits for those teachers who are retiring from the White Plains School District. The Severance Plan includes (1) life insurance policy of \$50,000.00, (totaling \$25,000.00 at age 65 and totaling \$2,000.00 at age 70), a dental benefit and a vision benefit. These benefits are based upon the length of service in the White Plains School District at the time of retirement.

LEGAL SERVICE PLAN

WHITE PLAINS TEACHERS ASSOCIATION TRUST FUND

LEGAL SERVICE PLAN

July 1, 2023

For Legal Service Plan assistance, please call or email:

Elizabeth Harold, Esq., Direct: (914) 461-3232 | Email: eharold@haroldsalant.com

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 your place of employment (see Reduced Fee # 10 & 11 below for member parent benefits).

INCLUDED SERVICES:

1. Consultation and General Advice (in office, by phone or virtually)
 - 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):
 - 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 matters
4. Purchase and sale of house, condominium or cooperative apartment (Member's primary residence)
5. Simple Will, including testamentary trust for child or children
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 the 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

REDUCED FIXED FEE SCHEDULE FOR NON-INCLUDED SERVICES:

1. Purchase or sale of house, condominium or cooperative apartment (non-primary residence): House or Condominium: \$1,500; Coop: \$1,750
2. Traffic Court matters: \$500 per pre-trial Court appearance or trial by agreement
3. Administration or Probate of Estate: 15% discount on attorney's fees. Applies for member, spouse, parents, and parents-in law.
4. Name change: \$1,000
5. Uncontested Adoption: \$1,200
6. Uncontested Divorce without Separation Agreement: \$1,200; Uncontested Separation or Divorce Agreement: \$1,200; excludes negotiation.
7. Personal injury actions: 25% contingency fee
8. Business and personal matters not set forth in the Fixed Fee Schedule: Fees shall be mutually agreed to by the attorney and client
9. Simple will, living will, medical care proxy and general power of attorney to parents and parents-in-law of members: \$750 per couple or individual (NY and CT residents only for documents prepared and signed at the White Plains, NY or Fairfield, CT office, as appropriate).
10. Referral to Elder Law attorney with 20% discount on attorney's fees. Applies for member, spouse, parents, and parents-in-law.

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

Elizabeth G. Harold, Esq.
Harold, Salant, Strassfield & Rotbard, LLP
Elizabeth Harold, Esq., Direct: (914) 461-3232 | Email: eharold@haroldsalant.com
Paula Thomas, Paralegal: (914) 358-7501 | Email: pthomas@haroldsalant.com
Elizabeth Harold's Cell Phone, Emergency Use: (617) 851-4078
Main: (914) 683-2500 | Fax: (914) 683-1279
81 Main Street, Suite 205 | White Plains, New York 10601

FINANCIAL COUNSELING

*Stacey Braun Associates, Inc.
377 Broadway
New York, NY 10013*

**\$\$ WPTA Welfare Trust Fund \$\$
FINANCIAL COUNSELING PROGRAM**

Services Available to Each Member (*at no cost*):

1. **Free financial consultation each year:** Consultations are held at the Staff Development Center, the local NYSUT office (in Tarrytown) or at Stacey Braun's office in New York City. You can receive up to six hours of time, in person or over the phone or in combination. **For more information or to schedule an appointment call 1-888-949-1925.** Spouses and/or other family members may attend consultations with you.
2. **Unlimited access to Stacey Braun's proprietary website:** This password protected website is a useful financial tool intended to address many of your financial concerns. The website contains financial narratives, market data, quotes, charts, portfolio tracking, financial news, financial glossary, financial calculators, links to other useful financial sites and the email helpdesk. To access the site use "money" as your password and "whiteplains" as the User ID.
3. **Unlimited use of Stacey Braun's email helpdesk:** To provide answers to basic financial questions, you have access to qualified professionals via Stacey Braun's email helpdesk.

Topics for consultations include, but are not limited to:

Retirement Planning, Refinancing, Mortgages, Debt Management, Budgeting, Divorce, Investments (403b, Pension Advice), Mutual Fund Questions, Asset Allocation, Establishing Risk Tolerance, Taxes, Inheritance Issues, Gifting, Estate Planning, Savings, Cash Flow, General Education, Elder Care, Social Security, Education Funding (i.e. 529 plans), Second Opinions & Life, Disability and Long-Term Care Insurance

***STACEY BRAUN PERSONNEL
ARE PROHIBITED FROM SELLING INVESTMENTS OR INSURANCE PRODUCTS***

STACEY BRAUN IS NOT AFFILIATED WITH ANY 403(b) PROVIDERS

COBRA

Extension of Benefits

COBRA – Extension of Benefits

Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), certain individuals are given the option of continuing their group health benefits under specific conditions.

You and your dependents are eligible to continue dental and vision coverage for up to 18 months if coverage ends due to:

- 1) layoff
- 2) a reduction in the scheduled work hours per week
- 3) voluntary termination of employment with the Welfare Trust Fund;
 or
- 4) discharge of employment

Insurance Programmers, Inc. will notify you of your right to continue coverage within 45 days of the occurrence or of IPI being notified of the occurrence.

An employee who (a) elects continuation coverage as the result of termination of employment and (b) is subsequently determined by Social Security to have been disabled as of the date of termination, is entitled to continue coverage for 29 months instead of 18 months.

Your dependents are eligible to continue their coverage for up to 36 months upon the occurrence of the following events:

- 1) The spouse, qualified domestic partner and children upon the death of the covered employee
- 2) The spouse, upon divorce or legal separation from the employee
- 3) Dependent children when they cease to be a dependent child under the definition of the plan.

You and your dependents must notify your Welfare Trust Fund Trustee or ASO of the occurrence of the events shown above. The notice should be given as soon as reasonably possible after the date the event occurred. Within 45 days of notice that an event ending a dependent's coverage has occurred, IPI shall send notice to your dependent of the right to continue the coverage.

To continue coverage, you or your dependent must apply in writing to IPI within 60 days of the later of 1) the date the coverage ends; or 2) the date you or your dependent receive notice of the right to continue the coverage.

You and your dependent must pay the required monthly amount for the continued coverage. ASO will inform you of the monthly amount. You or your dependent must also pay such amount for any period of continued coverage that began prior to the election of such continuance. The amount must be paid within 60 days after the date the continued coverage is elected.

The continued coverage will begin on the day after the date that coverage would have ended. It will end when the first of the following events occurs:

- 1) the Plan terminates;
- 2) the end of the period allowed for continued coverage;
- 3) the end of the period for which contributions were paid;
- 4) the date you or your dependent becomes covered under another plan;
- 5) the date your former spouse remarries and thereby becomes covered under another plan.

GENERAL INFORMATION

GENERAL INFORMATION

Coordination of Benefits Provision

Some individuals have coverage in addition to the benefits provided by this plan. When this happens, the amount of benefits payable under this plan will take into account any coverage a Participant has under “other plans” so the combined benefits under this Plan and the “other plans” will not exceed the total expenses. For purposes of coordinating benefits of multiple coverage, an “other plan” means any plan of benefits provided by:

- A. Group insurance or any other arrangement of coverage for individuals in a group which provides benefits or services on an insured or an uninsured basis;
- B. “No fault” automobile insurance, which is required under any law and is provided on other than a group basis; or
- C. Plans provided by the U.S. Government, State Government, etc.

In coordinating the benefits for a Participant having multiple coverage, the “primary” plan pays first and the “secondary” plan pays next to make up the difference, but the total benefit paid by both the primary and the secondary plans will not exceed 100% of the allowable expenses incurred. In addition, no plan will pay more benefits than it would normally provide without this coordinating provision. In determining which plan is primary and which plan is secondary, the following order will be used:

- A. A plan without a coordination of benefits provision will always be the primary plan; and
- B. If all plans have a coordination of benefits provision then:
 - 1) The plan covering the Participant as an employee is primary;
 - 2) The plan covering the Participant as a Dependent Spouse or qualified domestic partner is secondary;
 - 3) With respect to Dependent Children, the plan that covers a person as a dependent of an employee whose month and day of birth (NOT YEAR) occur earlier in the calendar year will be considered primary
 - 4) If the person is a dependent child of divorced or separated parents, the order will be as follows:
 - a) first, the Plan of the Parent with custody of the child;
 - b) then, the Plan of the spouse or qualified domestic partner of the parent with custody of the child;
 - c) finally, the Plan of the parent not having custody of the child.

However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, the benefits of that Plan are first.

WHEN SUBMITTING CLAIMS FOR MEMBERS OF THE FAMILY WHO ARE PRIMARY THROUGH ANOTHER CARRIER AND SECONDARY TO THE

PARTICIPANTS PLAN, A COPY OF THE PRIMARY PLAN'S PAYMENT EXPLANATION OF BENEFITS MUST ACCOMPANY THE CLAIM

When Coverage Ends

Your coverage ends when any of the following events occurs:

- 1) the last day of the month in which you leave your employ.
- 2) you are no longer eligible.
- 3) you cease to make the necessary contributions.
- 4) the Plan ceases.

A dependent's coverage ends when any of the following events occurs:

- 1) your coverage ends.
- 2) the dependent is no longer an eligible dependent.

NOTE: The benefits provided may be changed by the Board of Trustees. All provisions of the Plan are subject to such rules and regulations adopted by the Trustees.

Proof of Claim

Written proof of claim must be given to the Plan Coordinator, ASO, within 90 days after the date for which the claim is made. Late proof will be accepted only if it is furnished as soon as reasonably possible. Itemized bills and fully completed claim forms are required as part of proof of claim. No claim will be considered if submitted more than one year after the date of service.

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 Trustees. All appeals must be in writing and directed to the plan administrator, ASO. Please provide all information needed to support your appeal. The plan administrator will present it to the Trustees. Appeals must be received no later than 60 days after you receive the determination in question.

FAMILY MEDICAL LEAVE ACT
(FMLA)

**Your Rights Under The
FAMILY AND MEDICAL LEAVE ACT (FMLA) of 1993
As Federally Mandated**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons For Taking Leave

Unpaid leave must be granted for any of the following reasons:

- to care for the employee’s child after birth or placement for adoption, or foster care.
- to care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee’s job.

At the employee’s or employer’s option, certain kinds of paid leave may be substituted for unpaid leave.

Advance Notice and Medical Certification

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable”.
- An employer may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer’s expense) and a Fitness- for-Duty report to return to work.

Job Benefits and Protection

- For the duration of the FMLA leave (up to 12 weeks during a 12 month period), the employer must maintain the employee’s health coverage under any group health plan.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.

- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts By Employers:

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA:
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

Contact the Assistant Superintendent for Human Resources at 422-2216.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care and health care operations.

“Payment” includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to the following:

- 1) Determination of eligibility, coverage and cost sharing amounts, e.g., cost of a benefit, plan maximums and copayments as determined for an individual's claim,
- 2) Determining appeals and other payment disputes,
- 3) Billing, collection activities and related health care data processing,
- 4) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
- 5) Medical necessity reviews, or reviews of appropriateness of care or justification of charges,
- 6) Utilization review, including precertification, preauthorization of dental benefits and certain prescription drug benefits,
- 7) Disclosure to consumer reporting agencies related to collection of reimbursement,
- 8) Reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

- 1) Quality Assessment,
- 2) Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities.
- 3) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
- 4) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
- 5) Business planning and redevelopment, such as conducting cost management and planning-related analyses related to

managing and operating the entity, including formulary development and administration, development and administration, development or improvement of methods of payment or coverage policies,

- 6) Business management and general administrative activities of the entity, including, but not limited to:
 - a) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
 - b) Customer service, including the provision of data analyses, and
 - c) Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

A. The plan will use and disclose PHI as required by law and permitted by authorization of the participant or beneficiary.

B. For purposes of this section, White Plains Teachers Association Welfare Trust Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agree to:

- 1) Not use or further disclose the information other as permitted or required by the Plan Document or as required by law,
- 2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan sponsor with respect to such information,
- 3) Not use or disclose the information for employment-related actions and decisions unless authorized to do so by the individual,
- 4) Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized to do so by the individual,
- 5) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
- 6) Make PHI available to the individual in accordance with 45 CFR 164.524,
- 7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR 164.526,
- 8) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528,
- 9) Make internal practices, books and records relating to the use and disclosure of PHI received from the group health

plan available to the Secretary of HHS for the Purposes of determining compliance with 45 CFR 164, Subpart E, and

- 10) If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- A. Adequate separation between the Plan and Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following classes of employees may be given access to PHI:
 - 1) The Privacy Officer;
 - 2) The Plan Office Manager;
 - 3) Staff designated by the Plan Office Manager:
 - a) Health Plan staff responsible for general administration of the Health Plan including but not limited to eligibility determinations, customer service inquiries, and
 - b) Health Plan bookkeeper with access limited to the minimum necessary to complete the function of bookkeeping for the Health Plan
 - A. The persons described in section D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan, unless additional use or disclosure is authorized by the individual.
 - B. If the persons described in section D do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.
 - C. For purposes of complying with the HIPAA privacy rules, this Plan is a “hybrid Entity” because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.