New Rochelle Federation of United School Employees Welfare Fund

Summary Plan Description

July 2011

(updated July 2016)

(updated July 2018)

(updated August, 2020)

(updated August 2022)

New Rochelle F.U.S.E

Welfare Fund

270 North Avenue Suite 809
New Rochelle, NY 10801
Telephone: (914) 636-7999
Website: www.nrfuse.com

BOARD OF TRUSTEES

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TO ALL FUSE WELFARE FUND PARTICIPANTS

The New Rochelle Federation of United School Employees (FUSE) Welfare Fund (the "Plan or the "Fund") was originally established in 1969 through collective bargaining with FUSE (the "Union") and the City School District (the "Employer.")

In compliance with the contract negotiated by the Union, the City School District makes regular payments to the FUSE Welfare Fund.

This book is an important source of information. We urge you to familiarize yourself with the benefit program and the required procedures so that you understand your rights and obligations under this program. This document is intended to help you understand and use the benefits provided by the FUSE Welfare Fund. You should review it and share it with those members of your family who are or will be covered by the Plan. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this section.

The FUSE Welfare Fund has continuously expanded and improved the benefits that favorable claims experience, sound actuarial projections and finances permit. The Trustees, in consultation with the Union, and through careful management, provide the following benefits:

- Dental
- Vision
- Hearing
- $500 Medical Reimbursement
- $50,000 Life Insurance
- $50,000 Accidental Death and Dismemberment
- Telemedicine (terminated)
- Aflac Critical Illness (terminated)
- Long Term Disability (terminated)

Note: Eligibility requirements for benefits may differ, depending upon the benefit. Please read the eligibility requirements of each benefit as they are described later in this booklet.

This Plan is not established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The dental, vision, hearing and medical reimbursement benefits of the Plan are funded from the assets of the FUSE Welfare Fund. These assets are held in a Trust. The Life Insurance, Accidental and Death and Dismemberment, and Long Term Disability benefits of the Plan are fully insured with the First UNUM Life Insurance Company.

The ability of the Welfare Fund to continue to deliver the best welfare protection for all covered employees in our bargaining unit rests in large measure in your hands. Without the exercise of prudence, on your part, the Fund's fiscal integrity and viability would soon be eroded and destroyed. By complying with Fund rules and regulations, you can enable us to continue to process claims quickly and efficiently, thus keeping administrative costs at the lowest possible level.

We shall continue to exert our utmost efforts to improve the Welfare Fund so that it will meet all your needs and provide the best program that we can buy with the monies available. The FUSE Welfare Fund is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

The Trustees have discretionary authority to determine eligibility for benefits and to interpret and construe the terms of the plan and the Agreement and Declaration of Trust. All decisions of the Trustees shall be final, conclusive and binding on the plan participants.

All participants and dependents should be aware that to fulfill their fiduciary obligations the Trustees may from time to time be required to review the confidential medical and dental information of claimants.

Most important, be a Union member and support FUSE in the struggle to improve and expand employee benefits and rights.

If there are any questions concerning your benefit program, please do not hesitate to contact the FUSE Welfare Fund Office at (914) 636-7999.

Sincerely,
Welfare Fund Manager
New Rochelle FUSE Welfare Fund

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the telephone numbers listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
General Plan and Benefit Questions • Eligibility • Enrollment • Payroll deductions regarding spousal and/or dependent child(ren) dental benefits. • Information about USERRA, FMLA, and QMCSOs. • Request documents or other Plan related information • Contact the Board of Trustees	**Fund Office** **New Rochelle Federation of United School Employees** 270 North Ave Suite 809 New Rochelle, NY 10801 Telephone: (914) 636-7999 www.nrfuse.com
COBRA Continuation of Coverage and HIPAA Portability • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Certificate of Creditable Coverage • Self-payments for Continued Coverage	
HIPAA Privacy Officer /HIPAA Security Officer	

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Dental Benefit • Pre-determination of Dental benefits • Dental Claims **Vision Benefit** • Vision Claim Form • Vision Claims **Hearing Benefit** • Hearing Claims **Medical Reimbursement Benefit** • Medical Reimbursement Claim Form • Medical Reimbursement Claims	**Administrative Services Only** Department 27 PO Box 9005 Lynbrook, NY 11563 (516) 396-5500 / (718) 204-7172 Go online at www.asonet.com for a dental, vision, hearing or medical reimbursement claim form.
Life Insurance Benefits & Accidental Death and Dismemberment (Insured by First UNUM Life Insurance Company) • Change and/or update beneficiary information • Initiate a Claim • Claims Appeals – See your Certificate of Insurance from UNUM for information regarding their appeals procedure.	**Fund Office** **New Rochelle Federation of United School Employees** 270 North Ave Suite 809 New Rochelle, NY 10801 Telephone: (914) 636-7999 www.nrfuse.com

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
	Fund Office **New Rochelle Federation of United School Employees** 270 North Ave Suite 809 New Rochelle, NY 10801 Telephone: (914) 636-7999 www.nrfuse.com
Appeals for Dental, Vision, Hearing Aid and Medical Reimbursement Benefits Must Be Sent to: **New Rochelle Federation of United School Employees Welfare Fund** **270 North Ave.** **Suite 809** **New Rochelle, N.Y. 10801** **Attention: Appeals-Fund Manager**	

ELIGIBILITY

INITIAL ELIGIBILITY FOR YOU

To be eligible for benefits under the Plan, you must meet the following rules:

1. You must be an employee of the City School District of the City of New Rochelle, New York, or other employee deemed eligible by the Board of Trustees.
2. You must be working in full-time or half-time covered employment.
3. (a) Employees who cease employment may retain eligibility to the extent allowed by the Board of Trustees, provided they make application to the Trustees within thirty-one (31) days after ceasing employment and contributions on their behalf are made to the Fund in such amounts as the Trustees may determine.

   (b) Any participant who opted for COBRA continuation coverage and has paid 18 months of COBRA premium, may continue to purchase individual retiree dental coverage on a self-pay basis after the initial 18 month period. Payment for this coverage must begin the first of the month following the expiration of the COBRA continuation period (month 19).
4. Full-time employees of the New Rochelle Federation of United School Employees and the Welfare Fund are eligible to the extent allowed by the Board of Trustees and provided contributions on their behalf are made to the Fund.
5. Employees on leave, on whose behalf contributions are made to the Fund, are deemed to be in full-time covered employment.

See the summary of benefits chart at the end of this section outlining the benefits that are available.

EFFECTIVE DATE OF YOUR COVERAGE (WHEN BENEFITS BEGIN)

Your coverage begins September 1. Your dependents' coverage begins October 1. Coverage continues until September 30th of the following year.

CONTINUED ELIGIBILITY

Your coverage will continue as long as you meet the above requirements and contributions are made to the New Rochelle Federation of United School Employees (FUSE) Welfare Fund on your behalf.

ELIGIBILITY FOR YOUR DEPENDENTS & EFFECTIVE DATE OF COVERAGE

If you elect coverage for yourself, your Eligible Dependents are also eligible for coverage, however, coverage for dependent dental benefits requires payment of a premium. The premium is paid through payroll deductions that begin on the date you become eligible for your own coverage or the date you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have requested and activated coverage by submitting a completed written enrollment form that can be obtained from the Fund Office and you provide the Plan's required proof of Dependent status. A Dependent may not be enrolled for coverage unless the participant is also enrolled. See the Enrollment section of this document for additional information and the summary of benefits chart at the end of this section.

Your Eligible Dependents include:

- A Spouse that is recognized as your Spouse by the state in which you reside;
- A Domestic Partner as defined by the Plan (See pages 7 and 10 for information on eligibility and enrollment.)
- A Dependent Child, for the purposes of this plan, is any of the employee's/participant's children listed below who are under the age of 26 (whether married or unmarried):
  - **Son or daughter**
  - **Stepchild**
  - **Domestic Partner's child**
  - **Legally adopted child or child placed for adoption** with the employee/participant. Placed for adoption means the assumption and retention by the employee/participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.
  - Child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO).
  - **Foster child** lawfully placed with the employee/participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

For plan years beginning prior to January 1, 2014, a Dependent Child who is age 19 or older is not eligible for coverage under the Plan if such adult child is eligible for coverage under another employer-sponsored health plan other than a group health plan of a parent.

Except as provided below with respect to a disabled child, coverage shall terminate for a Dependent Child on the September 30th next occurring after their twenty-sixth (26th) birthday.

In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Plan:

- An unmarried Dependent Child (as defined above) age 26 or older who is **permanently and totally disabled** with a disability that existed prior to age 19 and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively **or/and** who will be claimed as a dependent on the employee's/participant's tax return for each plan year for which coverage is provided. The Plan will require initial and periodic proof of disability.
- An unmarried individual under age 19 with respect to whom the employee/participant has **legal guardianship** under a court order (proof of guardianship and age will be required) and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively **or/and**

who will be claimed as a dependent on the employee's/participant's tax return for each plan year for which coverage is provided.

With the exception of a Dependent Child who is permanently and totally disabled prior to age 19, coverage shall terminate on the September 30th next occurring after the child's twenty-sixth (26th) birthday.

It is the participant's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent child are NOT met with respect to any child for whom coverage is sought or is being provided.

ELIGIBILITY FOR YOUR DOMESTIC PARTNER & EFFECTIVE DATE OF COVERAGE

If you elect coverage for yourself, your Domestic Partner is also eligible for coverage. Premiums for your Domestic Partner's dental benefits are made through payroll deductions beginning on the date you become eligible for your own coverage or the date you acquire a Domestic Partner, but only if you have requested and activated coverage by submitting a completed written enrollment form that can be obtained from the Fund Office and you provide the Plan's required proof of Domestic Partner status. A Domestic Partner may not be enrolled for coverage unless the participant is also enrolled. See the Enrollment section of this document for additional information, and the summary of benefits chart at the end of this section.

DEFINITION OF DOMESTIC PARTNERS:

Domestic Partners are defined as two unmarried adults of the same or opposite sex, neither of whom are married or legally separated.

In addition the two unmarried adults of the same or opposite sex must:

A. Have resided together in the same residence for at least 12 months prior to this application and intend to do so indefinitely.

B. Be at least eighteen (18) years of age and mentally competent to consent to contract.

C. Be unrelated by blood closer than that which would otherwise prohibit legal marriage in the state in which they legally reside.

D. Have an exclusive relationship in which they are committed to each other's common welfare and are mutually responsible for basic living expenses.

E. Have not terminated the domestic partnership.

RETIREE'S ELIGIBILITY

When you retire you will be offered the opportunity to self-pay to continue your coverage under the Fund for dental, vision and hearing benefits. If you make the required payment, you will be reimbursed for dental, vision and hearing procedures based on the same schedule that applies to active employees.

When you first retire you will be given the opportunity to elect and self-pay for retiree benefits. **If you choose not to elect retiree benefits when you first retire, you will not be allowed to elect retiree coverage at a later date.** You must elect to do this within 30 days of when the benefits would otherwise terminate, or within 30 days of receipt of notice to continue benefits, whichever is later. Failure to timely elect and make payment shall make you ineligible for retiree benefits at any future date.

Each year the Trustees will establish the annual amount required to be paid by retirees for coverage. **This amount must be paid by October 1st of each year or your benefit eligibility will be terminated.** If your benefits are terminated because of this lack of payment, you will not be allowed to receive retiree benefits again in the future.

Your payment will cover you for the one-year period beginning September 1st for each year that you make the required self-payment.

The Trustees reserve the right to increase or decrease the amount required to be paid by retirees for coverage. The Trustees reserve the right to eliminate retiree benefits entirely. The Trustees reserve the right to change, increase or decrease eligibility requirements for retiree benefits. You should not base your decision about whether or not to retire on the expectation of continued retiree benefits.

RETIREE'S SPOUSAL BENEFIT

When you retire, your covered spouse may continue to receive benefits in one of two ways:

1. **By electing and paying for COBRA Continuation Coverage** which includes dental benefits, the medical reimbursement account and access to the vision benefit (available once per year per family). COBRA premiums are paid to the Fund. **COBRA Coverage lasts for 18 months only. Individuals receiving COBRA are not eligible to purchase the Fund's Self-Pay Benefits at the conclusion of their COBRA period.** Please see the "COBRA: Temporary Continuation of Health Care Coverage" section of this booklet for more information.

OR

2. **By electing and paying for Self-Pay Benefits** which include dental benefits and access to the vision benefit (available once per year per family). Self-Pay Benefits do not include the medical

reimbursement account. Self-Pay Benefits can continue indefinitely, as long as annual premiums are paid.

If you have any questions about the difference between COBRA Continuation Coverage and Self-Pay Benefits, do not hesitate to call the Fund Office.

SUMMARY OF BENEFITS

Benefits	Active Participant	Active Participant's Spouse or Domestic Partner	Children	Retiree	Retiree's Spouse or Domestic Partner
Dental	Yes	Yes through Self-Pay	Yes through Self-Pay	Yes through Self-Pay or COBRA	Yes through Self-Pay or COBRA
Vision	Yes*	No*	No for children age 19 and older.* ***Pediatric Vision Benefit For Children Prior to Age 19 Who Are Enrolled in the Dental Plan Through Self-Pay	Yes through Self-Pay or COBRA	Yes through Self-Pay or COBRA
Hearing	Yes	No	No	Yes through Self-Pay or COBRA	No
Medical Reimbursement	Yes	No**	No**	Yes Through COBRA only	Yes through COBRA only
Life Insurance	Yes	No	No	No	No
Accidental Death & Dismemberment	Yes	No	No	No	No
Critical Illness	Yes	No	Yes at 50% of benefit	Yes through self pay	No
Telemedicine	Yes	Yes	Yes	Yes	Yes

*Vision benefit is one (1) use per family per calendar year.

**Eligible out-of-pocket expenses as described in the Medical Reimbursement benefit section for your spouse, domestic partner, and eligible dependent child(ren) may be submitted for reimbursement up to your annual $500 maximum. See the Medical Reimbursement benefit section for additional information.

***** Pediatric Vision Benefit For Children Prior to Age 19 Who Are Enrolled in the Dental Plan:** Effective September 1, 2011, for children younger than age 19 who are enrolled in the dental plan through self-pay, one eye exam and one set of glasses will be covered up to the Plan's current dollar limits as shown in the schedule of vision benefits (accessible at www.nrfuse.org). A lens prescription change is required in order to obtain a new pair of glasses. See the "Vision Benefit" section of this booklet for more information.

ENROLLMENT

Enrollment is required in order for your benefits to begin.

HOW TO ENROLL - INITIAL ENROLLMENT

For You

You are automatically enrolled for the benefits provided by the FUSE Welfare Fund. You should complete an Enrollment Form, a Life Insurance Group Enrollment Form and Beneficiary Designation Card (that may be obtained from and submitted to the Fund Office).

For Your Dependents & Domestic Partner

You, as the participant/member, may decide to use your Medical Reimbursement and Vision Benefit (the vision benefit is once per family per year, except for children prior to age 19) for your eligible spouse or child in any given year. You may also elect dental coverage for them, but this requires payment of a premium.

In order to properly enroll your eligible dependents, you must fill out the Dependent Enrollment Form at the time you enroll for coverage (during the month of September), or within 30 days of the effective date of your coverage (following your Initial Eligibility) or within 30 days of the date you add a new Dependent. You must authorize payroll deductions for the dependent dental benefit, if elected, and provide the Fund Office with proof of dependent status. The Fund Office will accept a copy of any of the following documents as proof of dependent status:

- **Spouse/Marriage:** Copy of your certified marriage certificate. You must also notify the Fund if your spouse or children have other health benefits.
- **Domestic Partner**: Signed affidavit by the participant and domestic partner that they meet the requirements of this Plan's domestic partner (i.e., "spousal equivalent") eligibility using the Plan's "Affidavit of Spousal Equivalency" Form and Enrollment Form for the Spousal Equivalent Program. Proof of cohabitation must be provided.

To be eligible to cover a Domestic Partner under the Fund, the participant and Qualified Spousal Equivalent (QSE) must satisfy the following requirements:

1. You must apply for coverage as a Domestic Partner.

2. You must submit a notarized "Affidavit of Spousal Equivalency."

3. If you reside in an area that offers registration of Domestic Partners (such as New York and San Francisco), then you must register as Domestic Partners and submit the registration to the Fund.

4. If you reside in an area that does not offer registration of domestic partners, then you must submit to the Fund items listed in bullet point number 5, as one of the four required proofs of financial interdependence.

5. You must submit four of the following types of proof of financial interdependence:

    - Proof of a joint bank account (statement, check or passbook with both names)
    - Joint credit card accounts (statement with both names)
    - Joint loan obligations (note or other loan origination document with both names)
    - Joint ownership of a residence (deed or other sale/transfer document with both names; property or water tax document with both names)
    - Joint lease of a residence (lease with both names)
    - Common household expenses (phone, electric bills, with both names; public assistance document with both names)
    - Joint vehicle ownership
    - Joint wills (copy of will or wills, with each party naming the other as beneficiary and/or executor)
    - Power of attorney (copies of powers of attorney with each party naming the other party and no limitation on the term of the documents)
    - Health care proxy (copies of health care proxies/living wills, with each party giving the other party the power to make health care/non-resuscitation decisions upon incapacitation)
    - Life insurance (copy of policy with one party naming the other as beneficiary)
    - Retirement benefits (copy of beneficiary designation form with one party designating the other as beneficiary).

- **Child/Birth**: Copy of the child's certified birth certificate.
- **Adoption or placement for adoption**: Copy of court order papers signed by the judge.
- **Stepchild:** Proof of age and relationship will be required. A copy of the child's certified birth certificate and certified marriage certificate.

- **Domestic Partner's Child:** Proof of age and relationship will be required. A copy of the child's certified birth certificate and proof of domestic partnership.
- **Disabled Dependent Child:** Current written statement from your child's physician indicating the diagnoses that are the basis for the physician's assessment that your child is currently incapable of self-sustaining employment by reason of mental retardation, mental illness, developmental disability or physical handicap. This condition must have arisen prior to your child's attainment of age 19 and your child must depend chiefly on you and/or your spouse for economic support and maintenance. The Plan may require that you show proof of support and maintenance such as a copy of your IRS income tax return showing you claim the child as a Dependent. Proof of disability must be provided within 31 days of the date of your child's 19th birthday. The Plan may require subsequent proof, but will not request proof more than once a year after the initial two-year period that follows the Fund's determination that your child is eligible for coverage due to disability.

START OF COVERAGE FOLLOWING INITIAL ENROLLMENT

Your coverage begins on September 1 of the school year. Your spouse/domestic partner's coverage begins on October 1. Coverage of your enrolled Spouse, Domestic Partner, and/or Dependent Child(ren) begins on the date your coverage begins. The coverage will continue for the ensuing twelve months if a contribution is made for you as required by the Collective Bargaining Agreement between the Union and the District, and the necessary forms along with the supporting documentation is completed and filed with the Fund Office.

OPEN ENROLLMENT

Generally, Open Enrollment starts September 1 each year during which eligible employees may make the elections specified below. Enrollment forms and information may be obtained from the Fund Office.

Elections Available During Open Enrollment

During the Open Enrollment period, you may elect to **add or drop** your Eligible Dependent(s) and/or your Domestic Partner to the dental benefit. If you choose to add your spouse, domestic partner, and/or eligible dependent children you will be required to self-pay for their dental benefits through payroll deductions collected by the District.

The monthly premium for their dental coverage will be deducted from your paycheck starting with the first paycheck after Open Enrollment usually commencing by the October 15th paycheck. The self-pay dental premiums will be deducted each paycheck thereafter and will end with the last paycheck received in June.

Please note that if your Spouse, Domestic Partner, and/or Dependent Child(ren) are **enrolled for the first time during an Open Enrollment period**, that person's benefit will begin on the first day of the month (usually October) following the Open Enrollment. If you wish to drop dental benefits for your Spouse, Domestic Partner, or Dependent Children, you must do so in writing and during Open Enrollment. If you do, your request will become effective on the first day of October following Open Enrollment.

Very Important Information

Failure to Notify Fund about Dropping Dental Benefits During Open Enrollment: Once your dependents and/or Domestic partner are enrolled in dental benefits the payroll deductions for them will continue until they are disenrolled from the dental benefit. This can be done once per year during the annual open enrollment period. If your dependents have been enrolled for coverage and you fail to drop them during the Open Enrollment period this election will continue.

Failure to Enroll During Open Enrollment: If you fail to enroll any of your Eligible Dependents or Domestic Partner within the Open Enrollment period (unless your Eligible Dependents qualify for Special Enrollment described in the next section), you will not be able to enroll them until the next Open Enrollment period.

Caution: Open Enrollment procedures can differ from the process outlined above and if so, the procedure on how to enroll at Open Enrollment time will be announced by the Plan at the beginning of the Open Enrollment period.

SPECIAL ENROLLMENT

There is a special enrollment period from September 1 through March 31 of each year. During that period you may enroll a dependent who has lost the health coverage they previously had, or add a new dependent. This is explained further below.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after the employer stops contributing toward the other coverage and before March 31. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption and before March 31.

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Fund Office at New Rochelle Federation of United School Employees (F.U.S.E.) Welfare Fund at 270 North Avenue, Suite 809, New Rochelle, NY 10801 or call (914) 636-7999.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

According to Federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office can provide more details about enrolling your children in such cases. A statement that describes procedures on these orders is available upon written request, free of charge, from the Fund Office.

Termination of Benefits

TERMINATION OF YOUR BENEFITS

An employee's benefits under this plan will terminate on the earliest of the following:

1. Termination of employment or layoff, or leave of absence for which proper contributions are not received;
2. Termination of benefits by the Fund or the Fund's insurance carrier;
3. Upon becoming a member of the military, naval or air force of any country at war, declared or undeclared except as provided under the section entitled “Leave for Military Service.”
4. Notwithstanding anything in paragraphs 1 through 3 to the contrary, if you are not employed for a full school year, the following shall apply:
   (a) if all scheduled employer contributions are made on your behalf, your benefits will terminate on August 31;
   (b) if nine of ten employer contributions are made on your behalf, your benefits will terminate on the 1st day of the month following the last month for which an employer contribution on your behalf was received;
   (c) if eight or less of ten employer contributions are made on your behalf, your benefits will terminate on the last day of the month for which an employer contribution on your behalf was received;
   (d) provided that (b) and (c) shall not apply to an employee for whom a June contribution is received and who continues in covered employment at least for the following July, August and September.
5. The date of your death. However any eligible claims that you incurred will be processed even if received by the Fund Office after your date of death.

TERMINATION OF YOUR DEPENDENT’S OR DOMESTIC PARTNER’S BENEFITS

A **dependent's benefits** under this plan will terminate on the **earliest** of the following events:

1. Your covered Spouse or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren);
2. The date a dependent or domestic partner becomes an eligible employee under this plan;
3. The date a spouse becomes legally separated or divorced;
4. The date a domestic partnership ends;
5. The date on which the employee's coverage ceases; and
6. Upon proper written notice given by the covered employee and received by the Fund office during the month of September, coverage will terminate as of September 30th.

TERMINATION OF RETIREE BENEFITS

Retiree coverage ends on the earliest of:

- the last day of the month in which the Retiree fails to make required self-payment for benefits; or
- the date of the Retiree’s death; or
- the date the Plan is discontinued

NOTICE TO THE PLAN

You, your Spouse, or any of your dependent Children **must notify the Plan preferably within 30 days but no later than 60 days** after the date a:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce);
- Domestic Partner ceases to meet the Plan's definition of Domestic Partner;
- Dependent Child ceases to meet the Plan's definition of Dependent (such as the date a dependent Child turns age 26, or is no longer disabled.)

Failure to give this Plan a timely notice will cause your Spouse and/or dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental Handicap.

CONTINUATION OF COVERAGE

See the COBRA section for information on continuing your dental, vision, hearing and medical reimbursement benefits.

HIPAA CERTIFICATION OF CREDITABLE COVERAGE WHEN COVERAGE ENDS

When your coverage ends, you and/or your Covered Dependents and/or Domestic Partner are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your Covered Dependent(s) and/or Domestic Partner has ended. You can present this certificate to your new Employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

PROCEDURE FOR REQUESTING AND RECEIVING A CERTIFICATE OF CREDITABLE COVERAGE

A certificate will be provided upon receipt of a written request for such a certificate that is received by the Fund Manager within two years after the date coverage ended under this Plan. The request must be mailed to the Fund Manager and should include the names of the individuals for whom a certificate is requested (including Spouse, Domestic Partner, and dependent Children) and the address where the certificate should be mailed. The address of the Fund Manager is the Fund Office. A copy of the certificate will be mailed by the Plan to the address indicated.

See the COBRA section for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

YOUR BENEFITS DURING CERTAIN LEAVES OF ABSENCE

There are certain circumstances where you may be entitled to a leave of absence. This section describes how an approved leave of absence will affect your benefits provided by the New Rochelle Federation of United School Employees Welfare Fund. If you have any questions about how a leave of absence affects your benefit, please contact the Fund Office. However, you must contact your Employer to determine whether you are eligible for leave under the Family and Medical Leave Act (FMLA) and for your Employer's procedures for requesting a FMLA leave.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period for:

- the birth, adoption, or placement with you for adoption of a child;
- providing care for a spouse, child, or parent who is seriously ill;
- your own serious illness; or
- qualifying exigencies arising out of the fact that the active participant's spouse, son, daughter, or parent is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation.

The Family and Medical Leave Act (FMLA) allows you to take up to 26 weeks of unpaid leave during any 12-month period to provide care for a covered service member. If you are the spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a service member, you are now entitled to a total of 26 weeks of leave during a 12-month period to care for the service member. A covered service member is a member of the Armed Forces (including National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy (including on an outpatient basis) for a serious injury or illness. The injury or illness must have been incurred in the line of duty while on active duty, and it must be an injury or illness that may render the service member unfit to perform the duties of his/her office, grade, rank or rating. If you are taking this type of leave, along with FMLA for any other purpose (e.g., birth of a child), the combined total leave required during one 12-month period is 26 weeks.

During your leave, you can continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for a leave under the FMLA if you:

- have worked for a covered Employer for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 employees are employed by the Employer within 75 miles.

The Fund will maintain your eligibility status until the end of the leave, provided the contributing Employer properly grants the leave under the FMLA and the District continues to make the required contributions to the Fund. Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your covered dependents, the same as to active employees and their covered dependents. If you do not return to covered employment after your leave ends, you are entitled to COBRA continuation coverage when your leave ends. Call the District to determine whether you are eligible for FMLA leave. Call the Fund Office for more information about coverage during FMLA leave.

MILITARY LEAVE

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

DUTY TO NOTIFY THE PLAN

The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is contained in the Plan Information Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

PLAN OFFERS CONTINUATION COVERAGE

Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

PAYING FOR USERRA COVERAGE:

- If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.
- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA section for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

AFTER DISCHARGE FROM THE ARMED FORCES

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

USERRA allows you to apply your accumulated eligibility under this Plan toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When your accumulated eligibility is exhausted, you may pay for USERRA coverage under the self-pay rules of this Plan. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you can choose to freeze your accumulated eligibility and instead proceed to pay for the USERRA coverage under the self-pay rules (out-of pocket) of this Plan.

If the employee does not want to use their accumulated eligibility to pay for USERRA coverage, the employee can choose to freeze their accumulated eligibility and instead proceed to pay for the USERRA

coverage under the self-pay rules (out-of-pocket) of this plan. The Trustees would then have to decide how to handle reinstatement.

Call your Employer if you have questions regarding your entitlement to USERRA military service leave. Call the Fund Office if you have questions regarding health coverage during such leave.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

If your coverage ends while you are on an approved FMLA leave or USERRA military service, your coverage will be reinstated on the day you return to active employment (see the Leave for Military Service section for more details), subject to all annual and lifetime plan benefit maximums that were incurred prior to the leave of absence.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Plan will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

Dental Benefit

New Rochelle Federation of United School Employees (FUSE) Welfare Fund provides you with dental benefits that are self-insured and administered by Administrative Services Only.

Your spouse, domestic partner, and eligible dependent child(ren) are eligible for dental benefits if you enrolled them for dental benefits and are having payroll deductions for them. See the eligibility section of this document for additional information.

HOW THE PLAN WORKS

Dental benefits are paid in accordance with a "Schedule of Dental Benefits" that lists (1) the dental services covered under the Plan and (2) the maximum amount the Plan pays for each such service.

PRETREATMENT REVIEW ESTIMATES

Whenever you want to know your estimated dental expenses for certain treatments, you may use the pretreatment review estimate procedure. This procedure lets you know how much you will have to pay before you begin treatment.

This process is recommended for your benefit as it will give the dentist and plan member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. **Please note that a pre-treatment review estimate is not a promise of payment.**

A pretreatment review estimate is recommended when expenses will exceed $500 in a 90-day period, including the following:

- Pre-op periapical x-rays required for crowns, veneers, inlays and extractions
- Periodontal charting and x-rays required for surgical periodontal procedures
- Pre-op periapical x-rays of the entire arch required for fixed bridgework and removable bridgework

To obtain a pretreatment review estimate, you and your Dentist should complete the regular dental claim form, available from the Fund Office or ASO website (see the Quick Reference Chart at the beginning of this document for the web address). Send the form to Administrative Services Only (ASO) indicating the type of work to be performed along with pertinent x-rays and the estimated cost. Once it is received, ASO will review the form and then send you and your Dentist (within 30 days) a statement showing what the Plan will pay. Disclaimer: If the Plan's estimated payment is less than the Dentist's charges, you can still get the treatment but you will have to pay the difference.

SCHEDULE OF DENTAL BENEFITS

A chart outlining a description of the Plan's Dental Benefits is available upon request, free of charge or you can go online at www.nrfuse.org for a copy.

ORTHODONTIA SERVICES

The orthodontic benefits are payable if dental coverage has been in force for twelve (12) consecutive months with respect to the individual seeking orthodontic services. The claims for orthodontia services should be submitted as the services are performed.

The orthodontia services are subject to an overall lifetime maximum of $3,000 per person.

DENTAL BENEFIT LIMITATIONS

The following limitations apply to the dental benefits provided by the plan.

- **Oral Examination:** payable two times in a calendar year.
- **Prophylaxis:** payable two times in a calendar year.
- **Replacement of crowns:** payable once in thirty-six (36) months.
- **Replacement of bridges and dentures:** payable once in sixty (60) months.
- **Palliative treatment:** payable when no other treatment is rendered during the visit.
- **Sealant:** payable for unrestored molar teeth, to age 19 with a lifetime maximum of two applications per tooth.
- **Fluoride treatment:** payable prior to age 19, maximum payable is two applications per year.
- **Root Scaling, curettage, bite correction, or any combination, including prophylaxis per visit:** payable up to $560 per calendar year.
- **Periodontal Maintenance:** subject to the periodontal maximum and is payable only after surgery.
- **Periodontal surgery with charting and x-rays:** payable once in thirty-six (36) consecutive months
- **Specialist Consultation:** payable once per calendar year, per specialty
- **Implants:** payable up to a maximum of (6) implants per lifetime.

DENTAL BENEFIT EXCLUSIONS

Benefits are NOT payable for the following:

1. Services not listed on the schedule of benefits. You can contact the Fund Office or ASO to determine if a particular procedure is covered by the Fund.

2. If more than one dentist furnishes services or materials for one dental procedure, the Fund is liable for not more than its liability had one dentist furnished the services or materials.

3. Any charges for services or materials for which the individual is not legally required to pay.

4. Any charges for services or materials for cosmetic purposes. Cosmetic dental procedures performed while covered for benefits, as a result of an accident, and performed within twelve (12) months after the accident occurred, will be paid provided you were also insured under this plan at the time of the accident.

5. Replacement of any lost or stolen dentures, bridgework, or other dental appliance.

6. Orthodontic benefits, dentures, bridgework, crowns, inlays, or other abutment expenses during the first twelve (12) months an individual is insured.

(a) If the individual was covered by another plan immediately prior to initial coverage under this plan, the amount of time the individual was previously insured will be used to reduce or eliminate this twelve-month waiting period, provided proof of such immediate prior coverage is received by the Claims Administrator within thirty-one (31) days after it is requested.

(b) If dentures or bridgework becomes necessary to replace teeth extracted during the first twelve months of coverage, benefits are payable for these dentures or bridgework.

7. Once a denture, bridgework, or other abutment has been installed while covered hereunder, no benefits are payable for its replacement for a minimum of five (5) years. Once a crown or an inlay has been installed while covered hereunder, no benefits are payable for its replacement for a minimum of three (3) years.

(a) If the denture is an immediate temporary denture and is replaced by a permanent denture within twelve (12) months, benefits are also payable for the permanent denture.

(b) If the replacement or addition of teeth is required due to the extraction of one or more natural teeth, benefits are payable for a new denture or bridgework.

8. Benefits are payable only for services necessary to the care and treatment of the patient and only if performed by a licensed dentist. Dental prophylaxis performed by a licensed dental hygienist under the supervision and control of a licensed dentist will be honored.

9. Any portion of a dental procedure performed before the effective date of an individual's coverage or after the termination of an individual's coverage.

10. Any charges arising from war or any act of war, whether declared or undeclared.

11. Any charges for services or materials received from a dental or medical department maintained by your employer, a mutual benefit association, a labor union, the United States Government, or any state, province, or other political subdivision.

12. Claims in which you or your dependents are entitled to Workers' Compensation benefits.

13. Claims in which the treatment is rendered by a member of the same family, unless proof satisfactory to the Trustees is submitted which indicates that a charge for such service has been made and has regularly been made in the past and such charges have been paid in the past, and that a charge for such service would have been made in the absence of this plan.

14. When more than one method of treatment could provide a professionally acceptable result in the treatment of a dental condition based on common dental standards, the Fund will determine the

dental service on which payment will be made and the expense that will be included as covered expense regardless of which course of treatment you select.

Vision Benefit

The vision benefit provides:

- Standard vision examination and eyewear such as eyeglasses or contact lenses – one individual per family per year, plus pediatric vision benefit for children prior to age 19, if applicable (see below).
- Any family member using the standard vision benefit **MUST ALSO BE ENROLLED IN SUPPLEMENTAL DENTAL COVERAGE.**
- Lasik surgery allowance of $280.00 – one individual per family per lifetime.

PEDIATRIC VISION BENEFIT

For Children Prior to Age 19 Who Are Enrolled in the Dental Plan Through Self-Pay:

Effective September 1, 2011, for children younger than age 19 who are enrolled in the dental plan through self-pay, one eye exam and one set of glasses will be covered up to the Plan's current dollar limits as shown in the vision benefit schedule (accessible at www.nrfuse.org). A lens prescription change is required in order to obtain a new pair of glasses. Prescription swim goggles are also covered up to the Plan's current dollar limits for eyeglasses, once per child per year. Contacts are not covered, unless a letter from an ophthalmologist or optometrist is received by ASO stating that such contacts are medically necessary. This pediatric vision benefit terminates when the child is no longer 18 years old. On the child's 19th birth date, the vision benefit is one (1) use per family per calendar year.

SCHEDULE OF VISION BENEFIT

A chart outlining a description of the Plan's Vision Benefits is available upon request, free of charge or you can go online at www.nrfuse.org for a copy.

VISION BENEFIT EXCLUSIONS

Benefits are NOT payable for the following:

1. More than one payment per vision care benefit per employee or family member per calendar year.
2. Sunglasses or the tinting of glasses.
3. Services not listed on the schedule of benefits.
4. Any lenses which are not prescribed by an ophthalmologist, optician, and/or an optometrist.
5. Any frames which are not used to hold lenses prescribed by an ophthalmologist, optician, and/or an optometrist.
6. Claims in which you are entitled to Workers' Compensation benefits.
7. Any charges for services or materials which the individual is not legally required to pay.
8. Orthoptics vision training or aniseikonia.
9. Eye examinations for diseases of the eyes. (This is normally covered under your medical plan.)

10. Claims in which the treatment is rendered by a member of the same family, unless proof satisfactory to the Trustees is submitted which indicates that a charge for such service has been made and has regularly been made in the past and such charges have been paid in the past, and that a charge for such service would have been made in the absence of this plan.

HOW TO FILE A CLAIM OR APPEAL

For information regarding how to file a vision benefit claim, and how to appeal a denied claim, see the "CLAIM FILING AND APPEAL INFORMATION" section.

Hearing benefit

The Hearing Benefit includes an annual hearing exam and a hearing aid appliance for each ear once every three (3) years. The Hearing Benefit covers only the employee, not the spouse, domestic partner or dependents.

SCHEDULE OF HEARING BENEFIT

A chart outlining a description of the Plan's Hearing Benefit is available upon request, free of charge or you can go online at www.nrfuse.org for a copy.

If the hearing exam or hearing aid costs more than the amount indicated above, you are responsible for the difference.

HOW TO FILE A CLAIM OR APPEAL

For information regarding how to file a hearing benefit claim, and how to appeal a denied claim, see the "CLAIM FILING AND APPEAL INFORMATION" section.

medical Reimbursement benefit

OVERVIEW OF THE MEDICAL REIMBURSEMENT BENEFIT

The Medical Reimbursement Benefit provides eligible Participants with an annual maximum of $500 per family for the reimbursement of expenses that are generally not reimbursed by the health plan, such as co-payments, co-insurance and other eligible expenses. You must submit a claim for reimbursement of eligible expenses.

AVAILABLE AMOUNT & ANNUAL MAXIMUM

Your $500 annual family benefit will be debited for reimbursement of eligible expenses incurred by you, your eligible Dependents or domestic partner.

ELIGIBLE EXPENSES FOR MEDICAL REIMBURSEMENT BENEFIT

In order for the out-of-pocket expense to be eligible for reimbursement, it must meet all of the following:

1. It must **not** appear in the list of **MEDICAL REIMBURSEMENT BENEFIT EXCLUSIONS** in this booklet.
2. It must be documented by a detailed billing statement from the provider including the name, address, telephone number and tax identification number of the provider, nature of the medical services rendered and/or an explanation of benefits voucher from all other plans.
3. It must be rendered by a licensed provider as mandated by state law in the state in which you reside.

REIMBURSEMENT PROCEDURE

1. Complete the claim form and attach all copies of the itemized bills for the expenses incurred and the corresponding explanation of benefits vouchers from all health insurance plans covering the patient(s) after you have accumulated $500 in out-of-pocket expenses or at the end of the calendar year.
2. Submit your claim for reimbursement at the end of the plan year, or when your eligible expenses for the year have reached $500.
3. All claims for benefits must be postmarked no later than March 31st of the following year. It is your obligation to prove that a claim was mailed timely. You may wish to consider using certified mail.

MEDICAL REIMBURSEMENT BENEFIT EXCLUSIONS

The following is a list of services and supplies or expenses not reimbursable under the Medical Reimbursement Benefit.

The following expenses are not reimbursable:

- Long-term care services.

- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for a special course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Internal Revenue Code § 213.

- Premiums paid through salary reduction contributions under the terms of a Internal Revenue Code Section 125 plan.

HOW TO FILE A CLAIM OR APPEAL

For information regarding how to file a medical reimbursement benefit claim, and how to appeal a denied claim, see the "CLAIM FILING AND APPEAL INFORMATION" section.

Life insurance BENEFIT

If you die from any cause while you are covered under the Plan, the proceeds of this benefit will be paid after the Fund Office receives proof of your death. This life insurance benefit of $50,000 is insured and provided by First UNUM Life Insurance Company (UNUM) and is payable to your beneficiary. This amount shall be reduced to $32,500 when you reach age 70 and to $25,000 when you reach age 75.

NAMING A BENEFICIARY

You may name anyone you wish as your beneficiary for this benefit. Write the person's name in the appropriate space on your Life Insurance Card for your death benefits under your life insurance when you first enroll in the Plan. You may change your beneficiary at any time by filing a form approved by UNUM with the Fund Office. If you have named an irrevocable beneficiary, the Fund Office must receive, in writing, consent from the irrevocable beneficiary that you may change your beneficiary designation. The new beneficiary designation will be effective as of the date you sign that form. However, if UNUM has taken any action or made any payment before the Fund Office receives that form and written consent from an irrevocable beneficiary, if any, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, UNUM has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If UNUM makes a payment to a beneficiary who lacks the legal capacity to give a release, UNUM may pay up to $500 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies UNUM's legal duty to the extent of that payment and UNUM will not have to make payment again.

Also, at UNUM's option, UNUM may pay up to $500 to the person or persons who, in UNUM's opinion, have incurred expenses for your last sickness and death.

LOSSES NOT COVERED UNDER THE LIFE INSURANCE BENEFIT

The life insurance benefit does not cover any losses where the death is caused by, contributed to by, or results from:

- Suicide occurring within 24 months after your the initial effective date of insurance; and
- Suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion will apply to any amount that is subject to evidence of insurability requirements and UNUM approves the evidence of insurability form and the amount you applied for at that time.

HOW TO FILE A CLAIM OR APPEAL

For information regarding how to file a Life Insurance claim, and how to appeal a denied claim, see the "CLAIM FILING AND APPEAL INFORMATION" section.

ADDITIONAL INFORMATION REGARDING YOUR LIFE INSURANCE BENEFIT

See your Certificate of Insurance from UNUM information or details regarding:

- Portability;
- Accelerated Benefit;
- Continuation during total disability; and
- Conversion options.

NOTE: *This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern.*

Accidental Death and Dismemberment benefit

The accidental death and dismemberment benefit pays a benefit in the event of your death or for you in the event of a covered loss. The accidental death and dismemberment benefit is insured and provided by First UNUM Life Insurance Company (UNUM).

RECEIPT OF YOUR AD&D BENEFIT

If you have an accident that results in a dismemberment to you, you will receive an accidental dismemberment benefit. If you have an accident that results in your death, your beneficiary will receive an accidental death benefit.

NAMING YOUR BENEFICIARY

You may name anyone you wish as your beneficiary by filing the appropriate form at the Fund Office. Further, you may name more than one beneficiary to receive the accidental death benefit. You can change your beneficiary or beneficiaries at any time by filing a new form. For further information regarding naming your beneficiary see the procedures for naming your beneficiary under the "Life Insurance Benefit" section of this document.

THE AMOUNT OF YOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The benefit will only be paid if the accidental bodily injury results from one or more of the covered losses listed below within the 365 days from the date of the accident. Depending upon your loss, the Plan will pay either the full benefit or half the benefit as indicated below.

Schedule of Losses

For Loss Of	The Benefit Is	Payable To
Life	$50,000	Your Beneficiary
Both hands	$50,000	You
Both feet	$50000	You
Sight of two eyes	$50,000	You
One hand and one foot	$50,000	You
One hand and the sight of one eye	$50,000	You
One foot and the sight of one eye	$50,000	You
One hand	$25,000	You

One foot	$25,000	You
Sight of one eye	$25,000	You

ACCIDENTAL LOSSES NOT COVERED

The accidental death and dismemberment benefit does not cover any accidental losses caused by, contributed by, or resulting from:

- suicide and intentionally self-inflicted injury.
- active participation in a riot.
- participation in a felony.
- drug addiction.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- war, declared or undeclared, or any act of war.

NOTE: *This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern.*

long term disability benefit

(TERMINATED)

HOW MUCH WILL UNUM PAY IF YOU ARE DISABLED?

UNUM's maximum monthly disability benefit is $5,000. UNUM calculates your monthly disability benefit as follows:

1. It multiplies your monthly earnings by 60%.
2. Your gross monthly disability benefit is the *lesser* of: (a) the amount from line 1, or (b) $5,000.
3. UNUM subtracts from your gross monthly disability benefit any "deductible sources of income." (See "What Are Deductible Sources of Income" in your UNUM Certificate of Coverage.)
4. The amount that remains is your monthly disability benefit.

MINIMUM BENEFIT

The minimum monthly benefit is the greater of:

1. $100; or
2. 10% of the monthly benefit before deductions for other income benefits.

UNUM may apply this amount toward an outstanding overpayment.

MAXIMUM BENEFIT PERIOD

Age at Disability	Maximum Period of Payment
Less than age 62	To Social Security Normal Retirement Age
Age 62	60 Months
Age 63	48 Months
Age 64	42 Months
Age 65	36 Months
Age 66	30 Months
Age 67	24 Months
Age 68	18 Months
Age 69 or older	12 Months

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your elimination period. UNUM will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is the later of:

- 180 days, or
- the date your salary continuation payments end, if applicable.

Benefits begin the day after the elimination period is completed.

MINIMUM REQUIREMENT FOR ACTIVE EMPLOYMENT

- 20 hours per week

DEFINITION OF BASIC MONTHLY EARNINGS

"Basic monthly earnings" means your gross monthly income from the employer in effect just prior to the date of disability. It does not include commissions, bonuses, overtime pay and other extra compensation.

WAITING PERIOD

If you became eligible after the policy effective date, your waiting period ends on the first day of the month coincident with or next following the date you became eligible. You must be in continuous

active employment and eligible during the waiting period.

WHAT DISABILITIES DUE TO A PRE-EXISTING CONDITION HAVE LIMITED COVERAGE UNDER THE PLAN?

The Plan provides limited coverage for any disability caused by, contributed to by, or resulting from a pre-existing condition. A pre-existing condition is one for which:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

If your disability is caused by, contributed to by, or results from a pre-existing condition,

- you will not entitled to receive benefit payments during the first 12 months after your effective date of coverage;
- benefit payments are not payable for such period and will not be paid at any time; and
- to receive benefit payments after such period you must continue to be disabled and meet all other terms and conditions of the policy.

Benefit payments for which you qualified, but which you were not entitled to receive due to your pre-existing condition, will be included in calculating the number of weeks or months of benefits and number of payments you have received for all purposes under the plan.

HOW TO FILE A CLAIM

Obtain a claim form from the Fund Office.

You must give the Fund Office written notice of a claim within 30 days of the date disability begins. However, you must send UNUM written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given as soon as is reasonably possible.

UNUM, at its expense, has the right and opportunity to have you:

1. examined by a physician, other health professional, or vocational expert of their choice; and/or
2. interviewed by an authorized Company representative. This right may be used as often as reasonably required.

APPEALS FOR DENIAL OF BENEFITS

See your Certificate of Insurance from UNUM for information regarding its appeals procedure.

WHAT DISABILITIES ARE NOT COVERED BY THE PLAN

Your Plan does not cover any disabilities caused by, contributed by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot;
- Participation in a felony.
- War, declared or undeclared, or any act of war.

ADDITIONAL INFORMATION REGARDING YOUR LONG TERM DISABILITY BENEFIT

See your Certificate of Insurance from UNUM regarding:

- Continuity of Coverage
- What Happens to Coverage while the Participant is on a Family and Medical Leave of Absence
- Disability Plus
- Survivor Benefit
- What Disabilities Have a Limited Pay Period Under Your Plan
- What Happens If You Return to Work Full Time with the Employer and Your Disability Occurs Again and
- Exclusions & Limitations.

NOTE: *This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained within the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern.*

CLAIM FILING AND APPEAL INFORMATION

HOW TO FILE A CLAIM

Where to Get Claim Forms: Obtain a claim form from the Fund Office or online through the internet website listed in the Quick Reference Chart of the beginning of this document.

How to Complete a Claim Form for the Dental, Vision and Hearing Benefits:

1. Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."

2. The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Vision care Provider, Hearing care Provider or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
   - A description of the services or supplies provided.
   - Details of the charges for those services or supplies.
   - Diagnosis.
   - Date(s) the services or supplies were provided.
   - Patient's name, social security or ID number, address and date of birth.
   - Provider's name, address, phone number, professional degree or license, and federal tax identification number.

3. Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Claims Administrator.** This can reduce costs to you and the Plan.

4. Complete a **separate claim form** for each person for whom Plan benefits are being requested.

5. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this plan.

How to Complete a Claim Form for the Medical Reimbursement Benefits:

1. Complete the claim form and attach all copies of the itemized bills for the expenses incurred and the corresponding explanation of benefits vouchers from all health insurance plans covering the patient(s) after you have accumulated $300 in out-of-pocket expenses or at the end of the calendar year.

2. Do not submit your claim until the end of the plan year unless you have already met the full amount of the benefit.

3. All claims for benefits must be postmarked no later than March 31st of the following year.

TIME LIMIT FOR INITIAL FILING OF CLAIMS

All claims must be submitted to the Plan within 12 months from the date of service.

No Plan benefits will be paid for any claim submitted after this period.

WHERE TO SEND THE CLAIM FORM

Send the completed claim form, the bill you received (you keep a copy too) and any other required information regarding

Dental Benefit Claims to:

Administrative Services Only
Department 27
P.O. Box 9005
Lynbrook, NY 11563

Vision Benefit Claims to:

Administrative Services Only
Department 27-O
P.O. Box 9005
Lynbrook, NY 11563

Hearing Benefit Claims to:

Administrative Services Only
Department 27-H
P.O. Box 9005
Lynbrook, NY 11563

Medical Expense Reimbursement Claims to:

Administrative Services Only
Department 27-M
P.O. Box 9005
Lynbrook, NY 11563

Claims for Life Insurance Benefits along with proof of death to:

Fund Office
New Rochelle Federation of United School Employees
270 North Ave
Suite 809
New Rochelle, NY 10801

Claims for Accidental Death and Dismemberment and Long Term Disability Benefits along with proof of death to:

First UNUM Life Insurance Company
100 Northfield Drive
Windsor, CT 06095
(860) 731-5600/(800) 225-6413

CLAIMS DEFERRED FOR ADDITIONAL INFORMATION (PENDED CLAIMS)

Deferred or Pended Claims: A "Deferred or Pended Claim" is a claim that is held and not processed because the Claims Administrator requires additional information that is needed to determine if the claim is payable.

Claims Relating to Accidents: Processing of claims related to an accident may be Deferred or Pended until the Plan receives information about the details of the accident. If a claim related to an accident is Deferred or Pended, you will be notified as to what information must be submitted regarding the accident.

EXPLANATION OF BENEFITS (EOB)

When a claim is processed by ASO you will be sent a form called an Explanation of Benefits or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your out of pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

COORDINATION OF BENEFITS (COB) PROVISION

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits section for more information.

WHEN YOU MUST REPAY PLAN BENEFITS

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the vision or dental expenses were not paid or payable by you or your covered Dependent; **or**
2. you or your covered Dependent received money to pay some or all of those expenses from a source other than the Plan; **or**
3. you or your covered Dependent achieves any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the expenses for which Plan benefits were paid; or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan, or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;
6. then, the Plan will be entitled to:
    a. a refund from you or your Vision Care or Dental Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;
    b. offset future benefits if necessary in order to recover such expenses;
    c. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

REVIEW PROCEDURE IF YOUR CLAIM IS DENIED (CLAIM APPEAL PROCESS)

Written Notice of Denial of Claim

The Claims Administrator (ASO) will notify you in writing if payment of your claim is denied in whole or in part. It will explain the reasons why, with reference to the Plan provisions on which the denial was based. When applicable, you will be told what additional information is required from you and why it is needed.

You will be told what steps you may take to submit your claim for review and reconsideration (commonly called a claim appeal). Your request for review or reconsideration must be made in writing to the office where the claim was originally submitted within 60 days after you receive notice of denial.

Where to Send the Level 1 Appeal for Dental, Vision, Hearing and Medical Reimbursement Benefits
Send the written and any other required information to:

New Rochelle Federation of United School Employees Welfare Fund
270 North Ave
Suite 809
New Rochelle, NY 10801
Attention: Appeals-Fund Manager

The appeal review process works as follows:

LEVEL 1 APPEAL FOR DENTAL, VISION, HEARING & MEDICAL REIMBURSEMENT CLAIMS

If your claim is denied, or if you disagree with the amount paid on a claim, you may ask for a review. You have the right to review documents applicable to the denial and to submit your own comments in writing. Your claim will be reviewed by a person at a higher level of management than the one who originally denied the claim. If any additional information is needed to process your request for review, it will be requested promptly. The decision on any review of your claim will be given to you in writing. It will explain the reasons for the decision, with reference to the applicable provisions of the Plan.

Ordinarily, a decision will be reached within 90 days after receipt of your request for review. However, in special circumstances, up to an additional 60 days may be necessary to reach a final decision. You will be advised in writing within the 90 days after receipt of your request for review if an additional period of time will be necessary to reach a final decision.

LEVEL 2 APPEALS FOR DENIAL OF BENEFITS

If your claim for any benefits is denied, you will receive a written explanation. If you are still dissatisfied with the denial of your claim, you may appeal the denial, in whole or in part, by notifying the Trustees, in writing, of your desire to appeal. You must fully set forth the basis for your appeal and it must be postmarked not later than ninety (90) days after the date appearing on the written explanation of the Denial of Benefits. Address your appeal to the Welfare Fund Office as follows:

New Rochelle Federation of United School Employees Welfare Fund
270 North Ave
Suite 809
New Rochelle, N.Y. 10801

Attention: Appeals-Fund Manager

Your appeal shall be considered by the Trustees at their next scheduled meeting. You will be notified in writing of the decision of the Trustees and their reasons for granting or denying your appeal. In some cases, the Trustees may require additional information to decide the appeal. The Trustees may defer deciding your appeal.

APPEAL PROCESS FOR LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT AND LONG TERM DISABILITY BENEFIT CLAIMS

See your Certificate of Insurance from UNUM for information regarding their appeals procedure.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Vision and/or Dental Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, claim administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

COORDINATION OF BENEFITS (COB) FOR Dental, VisioN & Hearing Benefits

These provisions apply to the dental, vision and hearing benefits described in this booklet.

Coordination of benefits operates so that one of the plans (called the "primary plan") pays benefits first. The secondary plan may then pay the difference up to the allowable expenses. Any group plan that does not use these same rules or does not have any coordination of benefit rules will always pay first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Employee/dependent. The plan that covers you as an employee is primary, and the plan that covers you as a dependent is secondary. If you are insured as an active employee under more than one health insurance plan, the plan that has provided coverage for you the longest will be the primary plan.

Dependent child/parents not divorced or separated. If a dependent child is covered under both parents' plans, the plan of the parent whose birthday is earlier in the year will pay first (this is often referred to as the "birthday rule").

Dependent child/parents divorced or separated. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current Spouse does, the plan of the Spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree. If there is no court decree allocating responsibility for health care expenses, the plan of the parent with custody of the child pays benefits first. If the parent with custody remarries, then the primary plan will be that of the stepparent. The plan of the natural parent who does not have custody will pay third and the plan of the spouse of the non-custodial parent pays last.

Active/Laid-Off or Retired Employee: The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

Continuation Coverage: If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under

federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by the first rather than by this rule.

Longer/Shorter Length of Coverage: If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

- When this Plan pays second, it will pay 100% of "Allowable Expenses" less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If the other coordinating plan determines benefits on the basis of Usual and Customary Charges, this Plan will use the Negotiated Amount as the allowable expense.
- When benefits are reduced by a primary plan because a Covered Participant did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

THIRD PARTY LIABILITY

A. **Advance on Account of Plan Benefits**

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent, wrongful or other act (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions section), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
1. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).

B. **Reimbursement and/or Subrogation Agreement**

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

C. **Cooperation with the Plan by All Covered Individuals**

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree to:

1. reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and

3. notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
4. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. **Subrogation**

1. By accepting an Advance, the covered Employee and/or covered Dependents jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance.
2. Under its subrogation rights, the Plan may, at its discretion:
   - Start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
   - Intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

E. **Remedies Available to the Plan**

If the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. Apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
2. Obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires this Plan, to offer its eligible participants, eligible retirees and their covered Dependents (called "Qualified Beneficiaries") the opportunity to elect a temporary continuation of the group health coverage ("COBRA Continuation Coverage") for dental, optical, hearing and medical reimbursement benefits, when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your Dependents may continue the same coverage that you/they were enrolled in right before the COBRA-Qualifying Event except for Life Insurance, Accidental Death and Dismemberment benefits and Long Term disability benefits. These benefits are not available under COBRA Continuation Coverage.

You should receive COBRA information regarding your health plan directly from the New Rochelle City School District. If you wish to purchase COBRA continuation from the New Rochelle F.U.S.E. Welfare Fund you do not have to purchase COBRA for the New Rochelle City School District plan first. Each is available separately.

When you retire, you (the Retiree) have the option of electing COBRA Continuation Coverage or Retiree Self-Pay Coverage for yourself or your spouse (Retiree's Spousal Benefit coverage) after your spouse has completed the 18-month COBRA coverage period. Dependent Children are not eligible for Retiree Self-Pay Coverage or the Spousal Benefit coverage and only have the option of electing COBRA Continuation Coverage. If you do not elect COBRA continuation coverage when you retire within the timeframes described in the COBRA Election Notice, you will no longer have any rights to COBRA continuation coverage, even if you lose your Retiree Self-Pay Coverage. Your dependent children will be able to elect COBRA regardless of the choice you and your spouse make.

QUALIFYING COBRA EVENTS

The chart below shows when you and your eligible dependents may qualify for continuation coverage under COBRA, and how long your coverage may continue.

If You Lose Coverage Because of This Reason (a "qualifying event")	These People Would Be Eligible	For COBRA Coverage Up To
Your employment terminates*	You and your covered spouse and children	18 months**
Your working hours are reduced	You and your covered spouse and children	18 months**
You die	Your covered spouse and children	36 months

You divorce or legally separate	Your covered spouse and children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your covered spouse and children	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

*For any reason other than gross misconduct (and including military leave and approved leaves granted according to the Family and Medical Leave Act)
**Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title VXI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. Additionally, coverage can be extended for eligible dependents to a maximum of 36 months in the event of death or Medicare entitlement of the employee or divorce or legal separation.

HOW COBRA COVERAGE WORKS

The following is the address and telephone number of the person who is responsible for administering COBRA Continuation Coverage for the Fund:

Fund Manager
New Rochelle Federation of United School Employees
270 North Ave
Suite 809
New Rochelle, NY 10801
Telephone: (914) 636-7999

To protect your family's rights to COBRA coverage, keep the Fund Office informed of any changes of address for you and your family members.

ACQUIRING A NEW DEPENDENT(S) WHILE COVERED BY COBRA

If you, your spouse, or your dependent child elects COBRA and acquires a new dependent through marriage, birth, adoption or placement for adoption while enrolled in COBRA Continuation Coverage, that person may add the dependent to COBRA coverage for the balance of the COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage.

To enroll your new dependent for COBRA coverage, notify the Fund Office as soon as possible within 30 days after acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent. Legal proof of your relationship to the child must also be provided.

If COBRA coverage ceases for you, your spouse or your dependent child before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for the newly added dependent. Check with the Fund for more details on how long COBRA coverage can last.

LOSS OF OTHER GROUP HEALTH PLAN COVERAGE OR OTHER HEALTH INSURANCE COVERAGE

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent child loses coverage under another group health plan, you may enroll the spouse or dependent child for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse or dependent. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

MULTIPLE QUALIFYING EVENTS

If your covered dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continuation coverage not to exceed a total of 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your covered dependents may be eligible for 18 months of continuation coverage. During this 18-month period, if your dependent child ceases to be a dependent under the Plan (a second qualifying event), your child may be eligible for an additional period of continuation coverage. The two periods combined may not exceed a total of 36 months from the date of your termination (the first qualifying event).

NOTICE OF COBRA ELIGIBILITY

Your employer is responsible for notifying the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement. (However, you or your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status.) You or your eligible dependents are responsible for informing the Fund Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date of the event. Notice should be sent to the Fund Manager, New Rochelle Federation of United School Employees, 270 North Avenue- Suite 809, New Rochelle, NY 10801.

If you do not notify the Fund Office by the end of that period, your dependents will *not* be entitled to continuation coverage. After the Fund Office has been notified of a qualifying event, it will send you information about your COBRA rights. You will have 60 days from the date you and/or your eligible dependents receive that notice to elect for COBRA continue coverage.

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage. One or more covered dependents may elect COBRA even if the employee does not elect it. One member of the family may elect COBRA for other members of the family. COBRA Continuation Coverage may be elected for some members of the family and not others. In order to elect COBRA Continuation Coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event. A parent or legal guardian may elect or reject COBRA Continuation Coverage on behalf of covered dependent children.

MANNER IN WHICH YOU MUST PROVIDE NOTICE

The notice of any of these situations must be provided in writing. You may use a form that the Fund Office maintains or you may send a letter to the Fund Office containing the following information: your name, for which of the events for which you are providing notice, the date of the event, and the supporting documentation (e.g., dated signature page of divorce agreement).

Notice should be sent to:

Fund Manager
New Rochelle Federation of United School Employees
270 North Ave
Suite 809
New Rochelle, NY 10801

The notice may be sent first class mail or hand-delivered.

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the sections entitled "Cost of COBRA Continuation Coverage" and "Paying for COBRA Coverage", below, for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

PAYING FOR COBRA COVERAGE

You have to pay the full cost of continuation coverage as calculated under COBRA. If you are eligible for 29 months of continuation coverage due to disability, the law permits the Fund to charge 150% of the full cost of the Plan during the 19th to 29th month of coverage. Your first payment must be made within 45 days (initial grace period) after you elect to continue coverage. If this payment is not made when due, COBRA Continuation Coverage will not take effect. All subsequent payments will be due on the first day of each month for that month's coverage. There will then be a grace period of 30 days to pay these monthly payments. If payment of the amount due is not made by the end of this grace period, your COBRA

coverage will terminate. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

WHEN COBRA COVERAGE WILL BE CUT SHORT AND/OR ENDS

Once COBRA coverage has been elected, it will be cut short and/or end on the occurrence of any of the following events:

- Coverage has continued for the maximum 18, 29 or 36 month period.
- The group health plan of which you were a member terminates. If the coverage is replaced, you may be continued under the new coverage.
- You or your dependent(s) fail to make the necessary payments on time.
- You or a covered dependent(s) become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent becomes entitled to benefits under Medicare.
- You or your dependent(s) are continuing coverage during the 19th to 29th months of a disability, and the disability ends.
- Full details of COBRA Continuation Coverage will be furnished to you or your eligible dependents when the Fund Office receives notice that a qualifying event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.
- If COBRA coverage is cut short as described above, the Fund Office will send you a written notice as soon as practicable following his or her determination that COBRA coverage will terminate. The notice will set out why COBRA coverage will terminate early, the date of termination, and your rights, if any, to alternative individual or group coverage.

UNAVAILABILITY OF COVERAGE

If you or your enrolled dependent has notified the Fund Office in writing of your divorce, your legal separation or a child's loss of dependent status, or a second qualifying event, but you or your enrolled dependent is not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same timeframe the Plan follows for election notices.

FMLA AND COBRA

Taking a leave under the Family and Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur after the FMLA period expires, if the person does not return to work and thus loses coverage under their group health plan. Then the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the Participant notifies the Employer that they are not returning to employment prior to the expiration of the applicable maximum FMLA 12-or 26 week period, a loss of coverage could occur earlier.

ADDITIONAL COBRA ELECTION PERIOD UNDER THE TRADE ACT

If the U.S. Department of Labor (DOL) certifies you as eligible for benefits under the Trade Act of 2002, you may be eligible for both an additional 60-day COBRA election period and an individual health insurance tax credit. If you and/or your dependents did not elect COBRA during your initial election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan. Also under the Trade Act, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA Continuation Coverage. For more information about COBRA and the Trade Act, go to www.irs.gov and enter "HCTC" in the "Search" box on the home page, or call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. (TTD/TTY callers may call toll-free at 1-866-626-4282.) The Fund Office may also be able to assist you with your questions.

IF YOU HAVE QUESTIONS

If you have any questions about your COBRA continuation coverage, contact the Fund Office. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of 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.

LIFE INSURANCE CONVERSION

When you are no longer eligible for benefits, your group life insurance coverage ends. If you want to convert your group life insurance to an individual policy, you have 31 days in which to make this change. During this period, you must file an application and pay the first premium to First UNUM Life Insurance Company. The premium will be determined according to UNUM's customary rates at that time, as well as other factors described in UNUM's certificate of coverage. Contact the Fund Office to obtain forms and information to convert your life insurance benefit to an individual policy.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When your COBRA coverage ends, the Fund Office will provide you and/or your Covered Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan (including if applicable, COBRA coverage). If within 63 days after your coverage under this Plan ends, (including if applicable, COBRA coverage) you and/or your Covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your Covered Dependents, a health insurance policy, you may need this certificate to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your Covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan (including if applicable, COBRA coverage), and certain additional information that is required by law.

The certificate will be sent to you (or to any of your Covered Dependents) by first class mail shortly after this Plan knows, or has reason know, that your (or their) coverage (including, if applicable, COBRA coverage) under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated.

In addition, a certificate will be provided to you and/or any Covered Dependent upon receipt of a request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to the Plan Administrator whose address is listed below.

Please make all requests for certificates of creditable coverage to:

Fund Manager
New Rochelle Federation of United School Employees
270 North Ave
Suite 809
New Rochelle, NY 10801

Privacy of Your Health information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the FUSE Welfare Fund protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the Fund Manager. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

The FUSE Welfare Fund maintains a HIPAA Notice of Privacy Practices. If you would like to see (or obtain a copy of) the Fund's HIPAA Notice of Privacy Practices, please contact the Privacy Official (Fund Manager) at the New Rochelle FUSE Welfare Fund, 2 Hamilton Avenue – Suite 201, New Rochelle, New York 10801. Telephone: (914) 636-7999). The Notice describes how the Fund uses and discloses protected health information for eligibility and the Fund's self-insured benefits. It also discusses important federal rights that you have with respect to your protected health information. If you are making a request about benefits that are administered by ASO, you may contact them directly at: Administrative Services Only, PO Box 9005, Department 27, Lynbrook, NY 11563-9005; Telephone: (516) 396-5500.

Plan Amendment or Termination

This Plan may be amended by the Trustees at any time in accordance with the Agreement and Declaration of Trust.

In order that the Trustees may carry out their obligations to maintain a sound economical program dedicated to providing the maximum Benefits for members as a whole, the Trustees expressly reserve the right in their sole discretion:

- to terminate or to amend either the amount or conditions with respect to any Benefits, even though such termination or amendment affects Benefits or eligibility that have already accrued;
- to alter or postpone the method of payment of Benefits;
- to amend any other provisions of this Plan; or
- to interpret the provisions of this Plan.

Resolutions to amend the Plan are made by the Board of Trustees and become effective on the date as specified in the document or resolution amending the Plan. You will be notified in writing of any plan changes. However, if the obligation of all Contributing Employers to contribute to the Fund ceases, the Fund would have to terminate. In addition, the Trustees also have the power to terminate the Fund for other reasons.

Plan benefits and eligibility rules for Participants and dependents:

- are not guaranteed or otherwise vested;
- may be changed or discontinued by the Board of Trustees;
- are subject to the rules and regulations adopted by the Board of Trustees; and
- are subject to the provisions of the group insurance policy purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If termination were ever necessary, in accordance with the Agreement and Declaration of Trust the Trustees would use Fund assets:

- To pay necessary expenses;
- To pay such benefits as the Trustees determine should be paid and for such other purposes that the Trustees decide would best carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been dispersed. After all assets have been disbursed, the Benefit Fund would terminate.

GENERAL PROVISIONS

NAME OF THE PLAN

New Rochelle Federation of United School Employees (FUSE) Welfare Fund

PLAN SPONSOR/PLAN ADMINISTRATOR

The Board of Trustees of the New Rochelle Federation of United School Employees (FUSE) Welfare Fund, is the Plan Sponsor and the Plan Administrator.

PLAN ADMINISTRATION

The New Rochelle Federation of United School Employees (FUSE) Welfare Fund is administered by a Board of Trustees composed of union representatives. The address and telephone number of the Fund is 270 North Avenue, Suite 809, New Rochelle, New York 10801, Telephone (914) 636-7999.

Day-to-day duties for administering the Plan have been delegated to the Fund Manager and the Fund Office.

EMPLOYER IDENTIFICATION NUMBER (EIN)

23-7126811

NAME & ADDRESS OF UNION & EMPLOYER

New Rochelle Federation of United School Employees
270 North Avenue, Suite 809, New Rochelle, New York 10801

Board of Education of the City School District of New Rochelle
515 North Avenue, New Rochelle, New York 10801

PLAN YEAR

The Plan's fiscal records are kept on a Plan Year that is the twelve-month period beginning each September 1 and ending on the following August 31.

TYPE OF PLAN AND TYPE OF ADMINISTRATION

Employee Welfare Benefits Plan including:

1. Dental
2. Vision
3. Hearing
4. Medical Reimbursement

5. Life Insurance
6. Accidental Death and dismemberment
7. Long Term Disability (TERMINATED)

Dental, Vision, Hearing Aid and Medical Reimbursement benefits are self-insured and claims for these benefits are administered by Administrative Services Only, Inc. (ASO) located at 303 Merrick Road, Lynbrook, NY 11563. The funding for the benefits is derived from contributions made by the District on behalf of covered Employees.

An independent insurance company, First UNUM Life Insurance Company, administers and fully insures life insurance, accidental death and dismemberment, and long term disability benefits and provides payment of claims associated with these benefits.

CLAIMS REVIEW FIDUCIARY (CLAIMS ADMINISTRATOR)WITH RESPECT TO ALL MATTERS REGARDING ELIGIBILITY:

Fund Manager
New Rochelle Federation of United School Employees
270 North
Suite 809
New Rochelle, NY 10801

Claims are adjudicated at the addresses listed under the "Where To Send The Claim Form" subsection of this booklet.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Plan Trustees or on the Plan's Legal Counsel.

For disputes arising under those portions of the Plan insured by First UNUM Life Insurance Company, service of legal process may be made upon First UNUM Life Insurance Company at the address listed on the Quick Reference Chart, one of its local offices, or upon the supervisory official of the State Insurance Department.

BOARD OF TRUSTEES

The Trustees of the Plan are listed at the beginning of this booklet and below is their principal place of business:

New Rochelle F.U.S.E
Welfare Fund
270 North Avenue, Suite 809
New Rochelle, NY 10801
Telephone: (914) 636-7999
Website: www.nrfuse.com

COLLECTIVE BARGAINING AGREEMENTS

Parties to the Collective Bargaining Agreement relating to the Plan are the New Rochelle Federation of United School Employees and the Board of Education of City School District of New Rochelle. The current collective bargaining agreement and supplemental agreement contain provisions providing for contributions to the Fund is available for your examination upon written request to the Board of Trustees.

FUNDING MEDIUM

The New Rochelle Federation of United School Employees Welfare Fund is an Employee Benefit Trust that is the medium used for the accumulation of assets. Life and Accidental Death, Dismemberment, and Long Term Disability benefits are provided through purchase of insurance by the Trustees. Contracts of insurance are available for inspection, without charge, at the Fund Office.
Dental, Vision and Hearing Benefits are self-insured and administered by Administrative Services Only, Inc., a third party administrator.

INTERNAL REVENUE SERVICE NOTICE 88-120:

In compliance with I.R.S. Notice 88-120, the Fund maintains, at the Fund Office, a copy of the Fund's application for exemption from Federal income tax and a copy of the I.R.S. letter granting the Fund an exemption from Federal income tax. Please contact the Fund Manager if you wish to inspect or copy any of these documents.

DISCRETIONARY AUTHORITY OF THE TRUSTEES AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Trustees, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. The Trustees have the full discretionary authority to interpret the terms of the Agreement and Declaration of Trust.

NO LIABILITY FOR PRACTICE OF MEDICINE, DENTISTRY, VISION OR HEARING

The Plan, Trustees or any of their designees are **not** engaged in the practice of medicine, dentistry, vision, or hearing nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN (Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. **If you fail to do so, you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a Dependent Child who has a physical or mental Handicap.**

Submit such information in writing to the Fund Manager at the address shown in the Quick Reference Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below. See also the COBRA section for special timeframes applicable to those benefits:

Type of Information Needed	Date Information is to be Submitted to the Plan
• Change of name or address or the existence of other health care coverage for any covered person.	As soon as possible but not later than 60 days after the change or addition of other coverage.
• Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person.	Within 30 days
• Covered Dependent (spouse or child) becomes handicapped/disabled or is no longer handicapped/ disabled.	Within 30 days of the date the person becomes disabled or is no longer disabled.
• Covered child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan, loses student status, etc.)	Within 60 days of the date the child is no longer considered a Dependent.
• Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA. • Medicare enrollment or disenrollment.	See the COBRA section for timeframe.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Protected Health Information

A. Use and disclosure of Protected Health Information (PHI): 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. Coordination of benefits with other health plans,

3. Adjudication of health benefit claims, including appeals and other payment disputes,

4. Subrogation of health benefit claims,

5. Establishing contribution rates for contributing employers, including risk adjusting amounts as necessary based on enrollee health status and demographic characteristics,

6. Establishing employee contribution rates as necessary,

7. Billing, collection activities and related health care data processing,

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes,

9. Responding to participant and beneficiary (and their authorized representatives') inquiries about payments,

10. Obtaining payment under a contract for reinsurance, including stop-loss and excess of loss insurance,

11. Medical necessity reviews, or reviews of appropriateness of care or justification of charges,

12. Utilization review, including precertification, preauthorization, concurrent review and retrospective review,

13. Coordination of benefits,

14. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number, and name and address of the provider and/or health Plan), and

15. Reimbursement of individual overpayments to the Plan,

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

1. Quality Assessment,

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination,

3. Disease management, including asthma, diabetes and cardiac disease management,

4. Contacting of health care providers and patients with information about treatment alternatives and related functions,

5. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,

6. Underwriting, premium rating, and other activities relating to the creation, renewal and/or replacement of a contract of health insurance or health benefits,

7. 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), and administration of the stop-loss contract (including claims processing),

8. Conducting or arranging for medical review, and legal services,

9. Conducting or arranging for auditing functions, including carrier audits, audits of the self insured health benefit program, fraud and abuse detection and compliance programs,

10. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,

11. 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 for policyholders, Plan sponsors, or other customers,

    c. Resolution of internal grievances, and

    d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

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

C. For purposes of this section the Board of Trustees of New Rochelle Federation of United School Employees Welfare 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 agrees to:

1. Not use or further disclose the information other than 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 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 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 the access requirements of HIPAA,

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

8. Make available the information required to provide an accounting of disclosures,

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 by the Plan with HIPAA, 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.

D. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The Trustees,

2. The Fund Staff designated by the Trustees. Fund Staff have access to individually identifiable health information, including eligibility, enrollment, payroll deductions, salary information, COBRA, HIPPA, appeals and some claims information, through paper files maintained in the Fund office and through the Fund's computer system. Access is determined through the use of individual network passwords that are programmed according to the system instructions.

E. 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.

F. 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.

G. 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.

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