# Health Benefits Program


RETIREE WELFARE FUND

# BENEFIT BOOK RETIREE MEMBERS JAN.1, 2012 EDITION

# RETIREE WELFARE FUND


**16 Court St., 34th Fl., Brooklyn, NY 11241**

**(718) 624-2600 | WWW.CSAWF.ORG**





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# Contents

# Message From the Chairperson of the Board of Trustees

Dear Colleague:

It is the determination of your Trustees to provide you with the most comprehensive benefit program possible. Our years in retirement should be free of concern in regard to the cost of necessary health care. To that end, we have designed the benefit program described in this booklet to broaden and enhance the City provided health benefit program you have chosen. Certain benefits not included in the City provided benefit program are provided by the Fund such as coverage for dental, optical and hearing aid services. Other benefits have been added to enhance your City benefit program by providing extended medical care and catastrophic coverage.

We are proud of the benefit program we have developed and the dedicated, prompt and courteous service provided to you by the staff of the Fund.

You have my assurance that your Trustees and I are determined to provide you with an effective benefit program and courteous service.

Sincerely,

Ernest A. Logan
Chairperson
Board of Trustees

# Forward

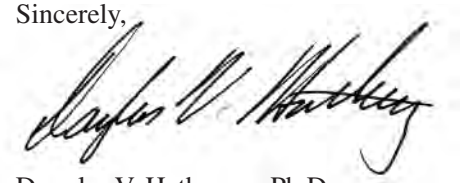
The Trustees of the CSA Retiree Welfare Fund are proud of the benefit program that has been developed over the years to provide our members with comprehensive protection from rising health costs. The program is unique in that it has been designed to provide members with choices. Members may choose a dental plan from a selection of four different plans, choosing between plans with little or no out-of-pocket costs or one which allows access to any dentist the member chooses to use. Optical services and hearing aid services are available either from a list of participating providers or through providers of the member's own choosing.

The Fund's benefit program is also unique in that it provides benefits not provided by other union health funds such as continued protection for surviving dependents of members who die. The Fund also has implemented a supplemental medical program to provide coverage for those services not fully covered by the City provided health plan or those excluded from the City provided health plan. In addition, a supplemental Major Medical benefit has been provided to assist members who incur medical and surgical costs not fully reimbursed by the member's primary medical plan, and a catastrophic medical (stop-loss) program to limit a member's financial risk to a reasonable level.

The continued success of the Fund depends upon two major ingredients, efficiency of operation and the cooperation of members. Members can help by including their social security number on all correspondence, notifying the Fund promptly of address changes, submitting changes in family status promptly, attaching original itemized paid receipted bills to all claims, auditing carefully the charges submitted by medical and dental practitioners before authorizing assignment of benefits to the practitioner, by using participating providers where possible and by submitting claims in a timely fashion.

The staff of the CSA Retiree Welfare Fund and I are dedicated to providing you with the best possible support and assistance with your health-related questions and issues so you are able to devote your time and energies to your retirement. We are proud of our history of providing the best possible support to our members and their dependents and assure you that we remain committed to providing this level of support in the years to come.

Sincerely,



Douglas V. Hathaway, Ph.D.
Administrator

# General Information

## Eligibility

You are eligible to receive benefits under the CSA Retiree Welfare Fund Program if:

- you are a Supervisory or Administrative employee who was separated from service with the Department of Education subsequent to June 30, 1970; and
- were covered by the CSA Welfare Fund at the time of such separation: and
- you are eligible for coverage by the City of New York to receive benefits; and
- remain a primary beneficiary of the NYC Health Insurance Program and supplemental Welfare Fund
- are entitled to benefits paid for by the City through such program and
- the City makes a contribution to the Fund to provide you with Welfare Fund benefits.

Your coverage is paid for by the City of New York on the basis of the terms of a contractual agreement between the CSA, the Department of Education and the City of New York. Your coverage remains in effect so long as contributions are made by the City on your behalf.

## Dependents

Coverage for Dependents is a member benefit and is provided at the request of the member. Eligible dependents of covered members are fully covered for all CSA Retiree Welfare Fund benefits. Dependents, as defined by the Fund, are: the legally married spouse (or registered domestic partner) eligible for coverage by the City-provided health benefit plan; dependent children who are under the age of 19, dependent children who are over the age of 19 but are unemployed or employed but not receiving benefits from their employer and have not reached their 26th birthday; any unmarried child, regardless of age, who is incapable of self-sustaining employment by reason of an extreme mental illness expected to be permanent, mental retardation, or a physical handicap and who became so incapable prior to attainment of age 19 and is wholly dependent on the covered employee for support. Applications for such disabled status must be made prior to the age of 19 or at the time of enrollment.

Where a claim is made by, or on behalf of, a person over 19 years of age who is eligible as a handicapped child, proof satisfactory to the Fund must be filed showing that the person is incapable of self-sustaining employment. This determination shall be made at the sole discretion of the Fund which may require that the individual submit proof of physical, psychiatric or other examination or evaluation.

Eligibility as a handicapped child is also dependent upon the child's eligibility for coverage by the New York City health insurance program. If the dependent child has been terminated for coverage under the New York City program, the Fund's coverage shall also be terminated.

A dependent child is defined as a natural child of the member, any legally adopted child, any stepchild who resides in your household, or any child supported by you or your spouse who permanently resides in your household and for whom you are legally responsible.

## Young Adult Age 26 Coverage

The Patient Protection and Affordable Care Act of 2010 ("Health Care Reform") requires that young adults not yet age 26 are eligible for continued coverage by the CSA Retiree Welfare Fund if the young adult is unable to attain comprehensive coverage from their own employment. To enable these young adults to be covered under their parent's plan, the member should contact the Fund to request the registration information.

## Domestic Partners

Members who wish to apply for coverage for a domestic partner can obtain details concerning eligibility, enrollment, and tax consequences from the Office of Labor Relations, Domestic Partnership Liaison Unit at (212) 513-0470.

Members who have registered a domestic partner for coverage by the City health plan and who are receiving such coverage will also be eligible for Welfare Fund Benefits for their domestic partner. Registration with the Domestic Partner Registry should be forwarded to the Fund when applying for Fund coverage.

## Enrollment

All new members must complete a CSA Retiree Welfare Fund Enrollment Card. Any changes in the member's family status such as marriage, divorce, separation, death of a dependent, the addition of a new dependent or change in designation of beneficiary require that the member request and complete a new enrollment card.

The Fund reserves the right to request documentation verifying the bona fide relationship of any dependent to the member (e.g. a birth certificate, marriage license, domestic partner registration, etc.) The Fund also reserves the right to deny or suspend benefits to members and/or their dependents when appropriate documentation of eligibility of the member or dependents is not provided to the Fund in a timely fashion and/or when requests for such documentation, or refund of monies paid by the Fund for ineligible dependents, is not provided to the Fund in a timely fashion.

## Termination of Dependent Coverage

Coverage with respect to a dependent will terminate upon the earliest to occur of the following dates:

- The date on which your personal coverage terminates
- The date on which the dependent fails to meet the criteria as a dependent under the plan
- The date the member requests that a dependent's coverage be terminated

## Continuation of Coverage

The Federal Government has enacted the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) which allows members and their eligible dependents the option of continuing their coverage for certain benefits provided by the City health plan and their Welfare Fund should their coverage be terminated. Under this law, the City health plan and the Fund will make available to the member, and/or his/her eligible dependents an opportunity to purchase most of the benefits at the group cost plus an administration charge not to exceed 2% of such cost. Your dependents are permitted to purchase their coverage for a period of up to 36 months on the following conditions:

a) Spouse and children upon the death of the covered member.*
b) The spouse upon divorce or legal separation from the member.
c) The spouse and children of Medicare eligible members should the member cease to participate in the Fund's benefit program
d) Dependent children when they cease to be dependent children as defined in the Plan.

Coverage by the Fund cannot be continued beyond any of the following dates:

a) The date on which the Fund terminates its benefit program,
b) The date the premium is not paid by the individual.
c) When the individual becomes covered under any other health plan (if that plan does not include any pre-existing limitations or exclusions) or is eligible for Medicare benefits.
d) In the case of a spouse, when the spouse remarries and

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## Continuation of Coverage CONTINUED

becomes covered under another group health plan. Federal COBRA rules do not apply for Medicare eligible members. However, as a result of a collective bargaining agreement the City and the unions have agreed to provide COBRA coverage to Medicare eligible members and their dependents.

Members are advised that if they wish to have continued coverage for themselves or any of their eligible dependents, they must notify the City Office of Labor Relations Employee Benefits Program, 40 Rector Street, 3rd Floor, New York, N.Y. 10006, as well as the Fund, within 30 days, should any of the following circumstances occur.

a) The member's coverage is terminated and no further contributions for coverage will be provided to the Fund by the City.
b) The member and spouse become legally separated or divorced.
c) A dependent child has reached his/her 26th birthday, is not married, unemployed or employed without benefits from employer The City Office of Labor Relations, Employee Benefits Program, will provide the member with a COBRA application, or in the case of an eligible dependent child over the age of 26, a Young Adult Age 29 application and explanatory material.

Upon notification to the Fund, by the member or the City, the Fund will send an application for continued coverage to the member and/or the eligible dependent. The application will indicate the benefits to be provided, the cost for the coverage and the manner in which payments are to be made to the Fund.

Your opportunity to continue to obtain benefits from the Fund under this optional paid program will be available to you for no more than 60 days from the time you receive the application for coverage. If the application is not filed within that period of time the Fund may not be able to offer such optional paid coverage.

* See "Survivor Benefits" section.

## Young Adult Age 29 Coverage

In compliance with New York State legislation, beginning October 1, 2010, young adults through age 29 may elect to obtain coverage from the appropriate Fund. Participants electing this coverage will be billed the Fund's actual cost for providing benefits, as determined by its actuary, on a monthly basis. Failure to pay the monthly premium amount is grounds for immediate termination.

Young adults are eligible for this coverage if:

- They are unmarried
- Are age 29 or younger
- Live, work or reside in New York State or the Fund's coverage area
- Are not covered by Medicare
- Are not eligible for coverage through an employer

## Information and Claim Forms

Information and literature concerning the coverage provided by the Fund, and claim forms for benefits, can be obtained by calling or writing the Fund. If writing to the Fund, members should indicate their social security number, as well as name and address. Claim forms for use under the GHI or other City basic health plans are obtainable directly from the insurance carrier, not from the Welfare Fund.

## Filing of Claims

Claims for all benefits provided by the Fund must be filed with the Fund no later than 12 months from the date services were rendered. Where the Coordination of Benefits provision is applicable, and the CSA Retiree Welfare Fund is the secondary plan, claims must be submitted within 12 months from the date payment was made under the primary plan. Claims that are not filed in accordance with the above time limitations will not be accepted.

RETIREE WELFARE FUND

# Coordination of Benefits (COB)

### *A. GENERAL*

You may be covered by two or more group health benefit plans, which may provide similar benefits. Should you have services covered by more than one plan, this Fund will coordinate benefit payments with the other plan. One plan will pay its full benefit as a primary insurer, and the other plan will pay secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a reasonable and customary charge. The Fund's program follows certain rules which have been established to determine which plan is primary; these rules apply whether or not you make a claim under both plans.

### *B. RULES OF COORDINATION*

The rules for determining primary and secondary benefits are as follows:

1. The plan covering you as an employee is primary before a plan covering you as a dependent.

2. When two plans cover the same child as a dependent, the child's coverage will be as follows: The plan of the parent whose birthday falls earlier in the year provides primary coverage. If both parents have the same birthday, the plan which has been in effect the longest is primary. If the other plan has a gender rule, (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See C below for special rules concerning dependents of separated or divorced parents.)

3. A laid-off or retired employee, or as a dependent of such a person, is secondary, and the plan covering you as an active employee, or as a dependent of such a person, is primary, as long as the other plan has a COB provision similar to this one.

### *C. SPECIAL RULES FOR DEPENDENTS OF SEPARATED OR DIVORCED PARENTS*

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan of the parent who has custody of the child is primary.

2. If the parent with custody of a dependent child remarries, that parent's plan is primary. The stepparent's plan is secondary and the plan covering the parent without custody is tertiary (third).

3. If the specific decree of the court states one parent is responsible for the health care of the child, then the benefits of that parent's plan are determined first. You must provide the Fund with a copy of the portion of the court order showing responsibility for health care expenses of the child.

### *D. EFFECT OF PRIMARY AND SECONDARY BENEFITS*

1. Benefits under a plan that is primary are calculated as though other coverage does not exist.

2. Benefits under a plan that is secondary will be reduced so that the combined payment or benefit from all plans are not more than the actual charges for the covered service. The plan that is secondary will never pay more than its full benefits.

If you and your spouse are both members of the CSA Retiree Welfare Fund, you can either be covered as a retired employee, or as a dependent but not as both. The Fund will pay benefits only once and will not coordinate with itself.

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### *NOTE*

Whenever payments have been made by the CSA Retiree Welfare Fund which are in excess of the maximum amount of payment necessary to satisfy a claim under the Coordination of Benefits Provision, the Fund shall have the right to recover such excess payments which were made to a member or eligible dependents.

## Non-Duplication of Benefits

The purpose of the basic City health insurance program, as well as the CSA Retiree Welfare Fund, is to provide the broadest coverage possible to members to enable them to meet their health and welfare needs. In line with this objective, the City health insurance program and the Fund have a non-duplication of benefits rule. Under this rule an employee cannot be covered both as an employee and as a dependent at the same time.

Therefore, if your spouse also works for or is retired from the Department of Education (or another City agency participating in the New York City health insurance program), you may either (1) each enroll separately, or (2) enroll one as the dependent of the other. If you enroll separately, you may each select a different plan, but one may not cover the other as a dependent and all children must be enrolled with the same parent.

Furthermore, if you enroll separately, coverage by the Fund for supplemental benefits to the City provided plan for dependents with separate coverage may be based on the supplemental coverage available to the member as determined by the member's City health plan.

## No-Fault Insurance

The Fund will not provide benefits for any services for which benefits are available under a No-Fault Automobile Policy.

## General Limitations and Exclusions Welfare Fund Benefits

Coverage under the CSA Retiree Welfare Fund will not apply to: an injury arising out of, or in the course of, any employment for wage or profit or a sickness for which benefits are provided under any worker's compensation or similar law; expenses incurred in a hospital owned or operated by any national government or any agency thereof; expenses incurred to the extent that payment is prohibited by any law of the jurisdiction in which the individual resides at the time the expenses are incurred; charges for which the individual is not legally required to pay or for charges which would not have been made if no insurance coverage had existed; such as services provided by a spouse, or by a parent to a child; charges in excess of the amount normally charged or considered by the Fund to be reasonable and customary; custodial care, education or training; injury or sickness arising out of war, declared or undeclared, or any act or hazard of war; charges for unnecessary treatment; charges for purely cosmetic surgery or treatment; expenses incurred which are in excess of the maximum annual or lifetime dollar limits established; for treatments which exceed the limit in the number of treatments established for that service; charges for services considered to be experimental or not generally accepted as an approved procedure or treatment program by the medical, governmental, or insurance community.

# Dental Benefit

***The CSA Retiree Welfare Fund offers to each member and his or her eligible dependents a choice of one of four different dental plans. There is a separate brochure (available upon request) for each of the plans that should be read carefully in order for you to understand the difference between the plans and your options, so that you can make an intelligent selection of the dental plan that best meets your needs. The following is a summary of these four plans.***

## The SIDS Dental Program—Option 1

Option I An Indemnity Plan Administered by Self Insured Dental Services

a) You can use any dentist of your own choosing anywhere in the world.

b) You are provided with a listing of dentists who have consented to be participating providers. As participating providers, they have agreed to accept the reimbursement listed in the "Schedule of Allowances" as payment in full, subject to any co-payments or maximum allowances listed in the "Schedule".

c) If you choose to go to a non-participating dentist, you are reimbursed on the basis of a Schedule of Allowances that is described in a separate brochure. Your reimbursement is, of course, subject to the limitations in the schedule and maximum allowances.

d) The cost incurred for implants and related services will be reimbursed up to a maximum of $3,000 in a 36 month period as defined in the Schedule of Allowances and as shown below

***REIMBURSEMENT FOR IMPLANTS AND IMPLANT-RELATED SERVICES SIDS Dental Plan***

| ADA Code | Description | Plan Pays | CSA Participating Provider Maximum Fee | CSA Retiree Co-Payment |
|---|---|---|---|---|
| 06010 | Endosteal Implant | $600.00 | $1,200.00 | $600.00 |
| 06040 | Subperiosteal Implant | $600.00 | $1,200.00 | $600.00 |
| 06050 | Transosseous Implant | $600.00 | $1,200.00 | $600.00 |
| 06056 | Prefabricated Abutment | $237.50 | $475.00 | $237.50 |
| 06057 | Custom Abutment | $237.50 | $475.00 | $237.50 |
| 06058 | Abutment Supported Porcelain Ceramic Crown | $337.50 | $675.00 | $337.50 |
| 06059 | Abutment Porcelain / Metal Crown | $337.50 | $675.00 | $337.50 |
| 06061 | Abutment Supported Crown | $300.00 | $600.00 | $300.00 |
| 06062 | Abutment Supported Cast High Noble Metal Crown | $337.50 | $675.00 | $337.50 |
| 06064 | Abutment Supported Cast Noble Metal Crown | $300.00 | $600.00 | $300.00 |
| 06065 | Implant Supported Porcelain Ceramic Crown | $487.50 | $975.00 | $487.50 |
| 06066 | Implant Supported Porcelain/High Noble Metal Crown | $487.50 | $975.00 | $487.50 |
| 06067 | Implant Supported High Noble Metal Crown | $487.50 | $975.00 | $487.50 |

# Healthplex Dental Plan for New York - New Jersey

***Option II Enrollment in a pre-paid dental plan, Dentcare Dental plan by Healthplex. For members residing, either full or part-time, in the New York City - New Jersey Metropolitan area***

a) This plan is a pre-paid dental plan similar in concept to an HMO. Your Fund pays for the cost of this plan.

b) A member who selects this plan, upon enrollment in the plan, must select a primary care dentist from an extensive listing of participating Dentcare dentists. You may not use any other dentist unless referred by your Dentcare dentist. Members who enroll in this dental plan may change primary care dentist during each annual open enrollment period or at any time if they are dissatisfied with their dentist

c) The participating Dentcare Dentist will provide a member and the member's eligible dependents with total dental care at no charge to the patient other than a small charge for two or three services listed in the descriptive materials relating to crowns and orthodontics.

d) Under this plan, there are no claim forms to be filed since the services are provided without a fee. The dentist is paid by the Fund each month, whether or not he has treated the patient. In effect, he, the dentist, is on a retainer for the services.

e) Specialized dental care, such as endodontics, oral surgery, and periodontics, if needed, is provided by specialists to whom your primary care dentist refers you.

f) This plan has no dollar maximums and there are few restrictions in terms of limitations and services.

g) Should you require emergency dental care while out of your geographic covered area, the cost for such care may be submitted to Healthplex for possible reimbursement.

# Healthplex S200 – Florida

***Option III A Pre-paid dental plan, Healthplex S200 Dental Plan of Florida, sponsored by Healthplex for members who reside, part-time or full-time, in Florida.***

a) This plan allows the participant to select any dental provider from the list of participating providers. A copayment is required for many services. While you may use any provider, the provider must be a participating provider in this dental plan. Treatment by a non-participating dentist is limited to the elimination of pain.

b) A member who selects this plan, upon enrollment in the plan, is eligible to receive benefits immediately upon the effective date of enrollment of coverage with: no waiting period, no deductibles, and no claim forms to submit. Members have access to participating providers (listing is found at https://yourdentalplan.com/healthplex or by calling customer service at 1-888-200-0322) and you may go to any participating dentist without referral.

c) Under this plan, because of Florida regulations, the dentist must charge a fee for some of the services listed in the Schedule of Benefits while other services are provided without charge.

# Delta Dental - Deltacare USA Plan 2a

***Option IV A prepaid dental plan, sponsored by Delta Dental***

This dental plan provided by Delta Dental provides cost free dental care for preventive services such as cleaning, x-rays and exams. Basic restorative services such as fillings are either free or at substantially reduced fees. Major restorative services such as crowns, bridgework, and orthodontic care will cost the member 50% or less than the usual and customary charge for these services.

The Deltacare dental plan is a most appropriate choice for members who reside in a geographic area in which there are few or no SIDS participating dentists or Healthplex dentists. The panel of participating dentists is very broad covering the states of Florida, Arizona, California, New Jersey, Georgia, and Virginia. A listing of dentists in your geographic area is available upon request.

Members who enroll in Delta Dental plan may change primary care dentists during each annual open enrollment period or at any time if they are dissatisfied with their dentist.

## Summary

You may enroll in any one of the four plans listed in the previous two pages.

If you do not submit an application for enrollment in either of the Healthplex plans, (Dentcare for retirees living in New York, New Jersey or the Healthplex S200 dental plan for members living in Florida), or the Deltacare USA Plan 2A, you will automatically be covered by the SIDS plan.

You will have an opportunity to change your dental plan during the annual open enrollment period each October through December for coverage effective January 1st of the next calendar year. Members will not be locked into any dental plan for more than the year in which they are enrolled. Members who make no changes each October will remain in the plan previously selected.

# Optical Benefits

***Eligible retirees, their spouses and eligible dependent children will be provided a choice of utilizing the services of participating optical centers through which a full service of benefits is provided without cost, or using non-participating optical centers and receiving reimbursement based upon a schedule of allowances. This benefit is provided once in a 12 month period.***

## Participating Centers

Members utilizing participating optical centers are provided with the following paid in full services: Eye examination (in New York State ONLY)* including Glaucoma testing for adults, single vision, bifocal, blended bifocal, or trifocal glass or plastic lenses, including oversized lenses, standard hard or soft daily wear contact lenses, and a wide choice of frames, including a selection of designer frames.

Members who desire frames or lenses not included in the participating center's selection may be subject to an additional surcharge by the optical center for these services beyond the Fund's allowance for frames or lenses.

## Direct Reimbursement

If you use an optical center or optician, which is not a participating center or optician, you must pay the center or optician directly, in which case you will be reimbursed by the Fund for the allowance to which you are entitled at right:

| | |
|---|---|
| Single vision lenses and frame | $65.00 |
| Bifocal and multifocal lenses and frame | $65.00 |
| Single vision lenses only | $35.00 |
| Bifocal or multifocal lenses only | $35.00 |
| Frame only | $25.00 |
| Contact lenses including all services | $65.00 |

## How to Obtain Benefits

Write or call the Fund office requesting an optical certificate. You must specify for whom the certificate is intended. Certificates are not transferable and must be returned to the Fund if not used. Provide your Social Security Number when submitting your request.

A list of participating optical centers will be provided to you with your optical certificate. The certificate is to be signed and given to the participating center when used. If a participating optical center charges you for services over the covered amount make certain that these additional costs are recorded on the voucher in the box on the left side of certificate for auditing by the Fund.

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## How to Obtain Benefits CONTINUED

Should you not use a participating provider, certificates must be completed, signed and returned to the Fund with an itemized paid receipt attached, showing proof of purchase in order for the Fund to provide the appropriate reimbursement.

**The person to whom the voucher is issued must, in all cases, sign the voucher in order for benefits to be provided. Unsigned vouchers will be returned for signature.**

** State laws in certain states such as New Jersey and Connecticut prohibit examinations at certain optical centers. Members are advised to check with centers outside New York State to determine if the eye examination is provided by that center without additional cost.*

# Visual Aid Machine Benefit

The Fund will include as a covered expense reimbursement of up to $500 towards the cost of a visual aid machine to assist members with severe visual loss. This benefit will be provided to members with severe vision impairment attested to by an ophthalmologist justifying the necessity for the device.

In order to apply for this once in a lifetime benefit, the member must submit an itemized bill for the device purchased, printed description of the device and a letter from a physician justifying the need for the device based upon the member's visual deficiency.

# Laser Eye Surgery Benefit

The Fund will include as a covered expense once in a lifetime benefit of up to $500 towards the cost of laser vision correction surgery. The Fund maintains a list of participating providers who have agreed to reduce their fees for CSA Retiree Welfare Fund members and will accept payment of the benefit directly from the Fund. Members can choose to have their laser eye corrective surgery at a non-participating provider with $500 reimbursement directly to the member.

***HOW TO OBTAIN BENEFITS***

Write or call the Fund office requesting a laser surgery benefit claim form. For direct reimbursement to members using non-participating providers, portions of the claim form must be completed by the member and the surgeon. The completed form should be returned to the Fund office for processing and payment. The form must be accompanied by a proof of payment such as an itemized paid, receipted bill for the services provided.

# Multi-Focal Lenses

Effective January 1, 2008, the CSA Retiree Welfare Fund provides supplemental reimbursement of up to $500 per eye for multi-focal lenses inserted after cataract surgery.

To obtain benefits, the member must submit an itemized paid bill to the Fund along with the Medicare explanation of benefits (EOB) when applicable.

# Hearing Aid Benefits

***All members and their eligible dependents, including children under the age of 26, are covered for hearing aid benefits.***

## Benefits

When using a participating provider, a benefit of up to $600, with a $35 co-payment made by the member to the participating provider, is provided for the purchase of one hearing aid every three years. The referral of a physician or an audiologist is required.

When choosing to use a non-participating hearing aid center, a direct reimbursement of up to $600 is made to the member.

## How to Obtain Benefits

Write or call the Fund office requesting a hearing aid benefit voucher. A listing of hearing aid providers who have agreed to provide our members with full hearing aid services at a reduced rate will be enclosed with the voucher. Portions of the voucher must be completed by the member, the physician or audiologist and the hearing aid dealer. For direct reimbursement for services obtained from a non-participating provider, the completed claim form should be returned to the Fund office for processing and payment. The claim form must be accompanied by a proof of purchase such as an itemized paid, receipted bill for the services provided.

**The person to whom the voucher is issued must, in all cases, sign the voucher in order for benefits to be provided. Unsigned vouchers will be returned for signature.**

# Home Health Aid Benefit

The Fund has established a Home Health Care benefit for members or dependents who require such services as certified by a physician. The purpose of this benefit is to provide necessary home care for members and/or eligible dependents who, on or after April 1, 2000, become incapacitated as a result of injury or illness and who, as a result of that injury or illness, cannot perform at least two activities of daily living without assistance as certified by the patient's primary care physician. Services must be provided by a licensed home care agency or certified home health aide who is not related to the patient. No reimbursement will be made if the service provider is paid in cash unless there is a receipt signed by the provider. The benefit provides reimbursement to an annual maximum of $6,000 with a lifetime maximum of $18,000. Claims are paid at 80% after the annual Home Health Aide benefit deductible of $100 is met and will be based upon the Fund's determination of reasonable and customary charges.

# Supplemental Medical Benefits

The City health plan for retirees, under 65 years of age, and the combined program of Medicare and supplemental City coverage for retirees over 65 does not include coverage, or limits coverage, for certain medical services. The Fund will cover the cost of a selected number of these uncovered, or limited covered, services under a supplemental medical program. These expenses are subject to a $100 per patient annual deductible with reimbursement provided at 80% of reasonable and customary charges, up to a maximum of $5,000 per patient in benefits, per calendar year. Services covered in this benefit program are:

a) Reimbursement of expenses for emergency ambulance

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# Supplemental Medical Benefits CONTINUED

services not fully reimbursed by the City basic health plan or Medicare.

b) Reimbursement of ambulance/ambulette service which is not of an emergency nature when there is a medical necessity for such service and when such transportation can not be accomplished by public transportation, automobile, taxi, etc., due to the handicapping condition of the patient. The treating physician must provide a statement of medical necessity and eligibility for this service must be pre-approved by the Fund. Approval is subject to the discretion of the Trustees. There is an annual maximum of $2,500 applied to this non-emergency ambulance/ambulette reimbursement.

c) The cost incurred for necessary casts, splints, orthopedic or orthotic devices for the feet (not including orthopedic shoes), not fully reimbursed by the City basic medical or Medicare program. Coverage for orthotic devices is limited to two sets of orthotic devices per patient, with a maximum reimbursement of $400 per pair.

d) Wigs required as a result of loss of hair due to chemotherapy and/or radiation therapy or for those patients diagnosed with alopecia areata. The coverage for wigs is limited to a maximum of $1,000 per year.

e) Reimbursement for surgical stockings is limited to a maximum benefit of $150 annually.

f) Nonpermanent or portable toilet seats, one per 12 month period.

g) Chiropractic care is included in all City health plans. Members who are **non-Medicare eligible** obtain these services **solely** through the City health plan in which they are enrolled. Members who are **Medicare eligible** are limited to twelve (12) chiropractic treatments per year. The Fund will provide reimbursement for up to 8 additional treatments, to provide a total of 20 covered treatments. Medicare eligible members must submit their Medicare Explanation of Benefits for the first 12 treatments along with their claims for any additional treatments in order to be reimbursed.

h) Physical therapy and speech therapy will be covered for up to a maximum of 20 treatments per calendar year offset by the number of treatments provided by the primary plan. For example, if GHI provides 8 such treatments, the Fund will cover an additional 12; if Medicare covers 12 treatments, the Fund will cover an additional 8.

i) Co-payment charges incurred by members enrolled in any of the City provided **HMO health plans** such as the $25 co-pay costs for HIP/HMO out-patient psychiatric treatments or office visits to HMO doctors or services.

j) The $300 patient deductible for hospital admission (imposed by the City health plan with a maximum of $750 deducted per calendar year).

k) Expenses incurred by members enrolled in GHI/Blue Cross and not fully reimbursed by that plan for surgery (including invasive diagnostic procedures such as colonoscopies and bronchoscopies), anesthesia, radiation and chemotherapy costs (exclusive of drugs) whether in or out of a hospital are covered.

l) Private Duty Nursing (by an RN, or LPN when an RN is not available, and when certified by the doctor as necessary) to an annual maximum of $10,000.

m) Costs associated with home infusion of antibiotics not covered by the primary health coverage, excluding the cost of medication. Costs for supplies and ancillary services are covered under this benefit, costs associated with administration of the medication through an intravenous port are covered under the private duty nursing benefit described above.

n) Prescription drug co-payments reimbursement for non-Medicare members enrolled in GHI for drugs obtained through the GHI drug program. Reimbursement is 80% after $100 RX deductible is satisfied, with a maximum of $10,000 annually. **Medicare eligible** members enrolled in GHI Senior Care with the optional rider as their Medicare D drug plan, are not reimbursed for prescription drug copays unless they exceed the applicable TrOOP amount for that year. If the TrOOP maximum is exceeded, reimbursement is 100% of copays thereafter to a maximum reimbursement of $5,000. (Please refer to the Prescription Co-pay Reimbursement Guidelines below)

o) Prescription drug co-payments of **non-Medicare** eligible members enrolled in an HMO plan are reimbursed at 80% after the $100 RX deductible is satisfied with a maximum of $10,000 annually. **Medicare** eligible members enrolled in an HMO plan are reimbursed at 80% after the $100 RX deductible is satisfied with a maximum of $5,000 annually.(Please refer to the Prescription Drug Co-Pay Reimbursement Guidelines below).

To file a claim for these services members should submit to the Fund a copy of the itemized bill, a prescription or statement of medical need by the doctor for the service, and a copy of the action taken by the basic health plan (GHl, Medicare, etc.) if any, in regard to that plan's reimbursement or denial of payment for that service.

**There are three (3) separate annual deductibles of $100 for Home Health Aide, Prescription drug co-payments and Supplemental Medical benefits**

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# Supplemental Medical Benefits CONTINUED

***GUIDELINES FOR PRESCRIPTION DRUG CO-PAY REIMBURSEMENTS AND CLAIM SUBMISSION***

## For Non-Medicare Retirees

Reimbursement of drug co-payment* expenses is 80% after the annual $100 deductible, with an annual maximum of $10,000 for members enrolled in a City basic health plan with the optional rider for prescription drugs. This benefit is separate from the Fund's Supplemental Medical or the Catastrophic Medical benefit.

The above applies to eligible spouses (or registered domestic partners) who have **their own** prescription drug plan as well. Please submit a description of the spouse / partner's plan along with claim submission in order to facilitate determination of allowable benefit.

If the spouse is a retired UFT member with membership in SHIP, copayments are to be submitted to SHIP first. Kindly submit explanation of benefits or denial from SHIP for applicable coordination of benefits.

## GHI City Plan + Optional Rider

An Express Scripts Summary of Benefits is sent out quarterly from GHI. This statement is the only acceptable document used for processing. Please submit all 4 quarters at the end of the year. Processing takes place during March/April of following year.

## HMO or Other City Plan + Optional Rider

• Submit printout from pharmacy or mail service used for purchases. The printout must include: total amount paid by insurance, name of drug, strength, quantity, date dispensed and amount paid by member.

• If a printout is not accessible, call the Fund to request receipt submission forms. Kindly paste or tape individual receipts from the pharmacy in chronological order. Please use a separate form for each patient. These receipts should also contain the information listed above.

***PLEASE NOTE:***
*Internet generated printouts will not be accepted.*
**If the drug plan pays $0, the out of pocket cost is not considered a co-pay and there will be no reimbursement*

## For Medicare Retirees

***GHI SENIOR CARE + OPTIONAL RIDER (MEDICARE D ENHANCED PDP RX PLAN)***

• $480 automatic reimbursement to offset rider premium cost for one person in the family

• If out-of-pocket costs (TrOOP) exceeds yearly maximum, (ex: $4,700 – 2012), 100% reimbursement of additional co-pay costs with annual maximum of $5,000.

• For reimbursement of these costs, submit copies of all pages of the GHI ENHANCED MEDICARE PDP printouts including the first page (showing name and address of recipient), onlywhen your TrOOP ("Amount You Paid" column) exceeds amount applicable for that year.

***GHI SENIOR CARE – NO OPTIONAL RIDER***

• No co-pay reimbursement/no premium reimbursement.

***GHI SENIOR CARE without Optional Rider + ANY OTHER MEDICARE D RX PLAN (for example, AARP)***

• Reimbursement of drug co-payment expenses at 80% after the annual $100 deductible, with an annual maximum of $5,000.

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## For Medicare Retirees CONTINUED

• Please submit description of drug plan for determination of allowed benefit along with pharmacy or mail service printout.

***HIP/VIP Medicare Plan OR OTHER HMO Medicare CITY PLAN + OPTIONAL RIDER***

• HIP/VIP members must submit the Enhanced Medicare PDP Printout listing their prescription drug purchases. Other HMO Medicare plan participants must submit the printout from the pharmacy or mail service used for purchases. The printout must include: total amount paid by insurance, name of drug, strength, quantity, date dispensed and the amount you paid. Maximum reimbursement is $5,000 per year.

• If a printout is not accessible by the plan being used, call the Fund to request receipt submission forms. Kindly paste or tape individual receipts from the pharmacy in chronological order. Please use a separate form for each patient. These receipts should also contain the information listed above.

***PLEASE NOTE:*** *Internet generated printouts will not be accepted.*

***IMPORTANT:*** *If a CSA retiree has waived his/her City health plan and/or optional rider and is covered by a spouse/partner's plan, the Fund must have a detailed description of the plan being used for determination of benefit allowed. Medicare eligible members covered by another GHI-Senior Care City plan are not eligible for drug copay reimbursement unless they exceed the TROOP applicable for that year. **(See note)*

## Survivors of Deceased CSA Retirees

***CITY COBRA + RIDER (Medicare & Non-Medicare)***

Reimbursement of drug co-payment expenses at 80% after the annual $100 deductible, with an annual maximum of $5,000.

***GHI***

Express Scripts Summary of Benefits or the GHI PDP printout that is sent from GHI. This statement is the only acceptable document used for processing. Submit each quarterly report as it is received throughout the year.

***HMO RX PLANS***

• Please submit printout from pharmacy or mail service used for purchases. The printout must include: total amount paid by insurance, name of drug, strength, quantity, date dispensed and amount you paid.

• If a printout is not accessible, call the Fund to request receipt submission forms. Kindly paste or tape individual receipts from the pharmacy in chronological order. Please use a separate form for each patient. These receipts should also contain the information listed above.

***Internet generated printouts will not be accepted.***

***OTHER MEDICARE SUPPLEMENTAL PLAN WITH RX BENEFITS***

Reimbursement of drug co-payment expenses at 80% after an annual $100 deductible, with an annual maximum of $5,000.

***OWN PLAN + RX PLAN- (Non-Medicare)***

• Reimbursement of drug co-payment expenses at 80% after an annual $100 deductible, with an annual maximum of $5,000.

• Please submit detailed description of the prescription drug plan being used for determination of benefit allowed.

***EXCLUSION:*** *Out-of-Pocket expenses for prescription drugs purchased through various pharmacies offering a $4 cost for generic drugs are not considered co-pays. Therefore, there is no reimbursement for this out-of-pocket expense.*

# Catastrophic Stop Loss Benefit

***Members and/or Dependents enrolled in HMOs***

Should a member or eligible dependent incur out-of-pocket expenses for covered services during a calendar year not provided by or fully reimbursed by the HMO, exclusive of hospital charges, the Fund will reimburse such expense at 80% until the Fund has reimbursed $1,000 after a $1,000 deductible has been met. Thereafter the Fund's reimbursement will be at 100% to an annual maximum of $50,000. The annual lifetime benefit is $250,000 per person. Hospital charges are not considered a covered expense.

***Non-Medicare Eligible members and/or Dependents Enrolled in GHI.***

Should a member or eligible dependent use doctors who do not participate in the GHI program and, therefore, incur out-of-pocket expenses not reimbursed by GHI in excess of $1,000 during a calendar year for covered services, the Fund will provide reimbursement of such expense at 80% until it has paid $1,000. Thereafter, reimbursement will be made at 100% to an annual maximum of $50,000. Such reimbursement will be based on current reasonable and customary charges for necessary care and treatment. Included in the accumulation of the out-of-pocket costs are all deductibles and co-insurance charges applied by GHI, Blue Cross, and the Welfare Fund, exclusive of hospital charges other than the $300 per admission deductible. The annual lifetime benefit is $250,000 per person.

***Medicare Eligible members and/or Dependents Enrolled in GHI***

The Fund will provide the same benefit coverage as described above except that Medicare allowed charges will determine the Fund's reimbursement of expenses in excess of the $1,000 annual deductible. Charges in excess of Medicare guidelines will not be considered.

Effective January 1, 2006, expenses for medical services provided by non-Medicare providers will be covered by the Fund's Catastrophic Medical benefit. The allowances for these services will be based on Medicare rates or 50% of the 50th percentile of current reasonable and customary charges.

## Hospitalization Coverage

Coverage for hospitalization is provided by the basic City health plan for members enrolled in HIP-HMO or any of the other HMO plans offered by the City to its active or retired employees.

The City provided coverage for members enrolled in Empire Blue Cross and GHI/CBP provides hospitalization coverage for 365 days in full for retirees under 65 years of age. For retirees over 65 years of age covered by Medicare, extended coverage for 365 days plus other additional benefits such as coverage for prescription drugs is offered only through the purchase of an optional benefits rider. The CSA Retiree Welfare Fund has assumed the cost to the City to provide CSA Retirees enrolled in either GHI/CBP or GHI Type C with 365 days of hospitalization coverage. Members enrolled in either of these plans will automatically be covered for this benefit. Members who purchase the optional benefits rider will not be charged for the cost of the extended hospitalization part of the rider. They will only pay for the other benefits such as prescription drugs.

***Note: The Fund's coverage for extended hospitalization for the member and his/her eligible dependent can only be applied if the Basic Health Plan (GHI/CBP or C) is in the name of the CSA Retiree.***

# Survivors' Benefits

The CSA Retiree Welfare Fund provides surviving dependents continued coverage for a period of up to sixty months from the date of the member's death without cost to the surviving dependent. The coverage currently in effect; dental, optical, hearing aid and supplemental medical will be provided to surviving dependents without cost.

The dependent will not need to purchase this Welfare Fund coverage under the COBRA provisions. In order to receive supplemental medical benefits from the Fund however, the surviving dependent must obtain coverage from the basic City health plan under the City's COBRA provisions or have the equivalent coverage through another health plan.

Once the sixty months have expired, benefits may be extended for as long as the survivor elects to pay a monthly premium equivalent to the current COBRA premium.

Survivors are not covered for extended hospitalization benefits. This coverage is only available through the City health plan or other similar coverage.

Coverage by the Fund will be secondary to any other coverage the dependent may have through an employer or private paid plan and payment by the Fund will be coordinated.

A survivor will be considered an eligible dependent if the survivor is the legally married spouse or registered domestic partner of the deceased member, a dependent child under 26 years of age, a handicapped dependent child unable to sustain his or herself will be considered eligible without limitation to age provided that handicapping condition occurred prior to the dependent's 19th birthday.

Coverage will terminate sixty months after the date of the member's death, re-marriage or when a dependent's status terminates, whichever comes first if continued coverage arrangements have not been made.

# Denial of Claims and Claims Review Procedure

In the foregoing pages, and in separate brochures describing the dental programs, specific instructions are furnished as to the proper procedure and time limitations for filing of claims. Where the benefit involved is furnished through an insurance carrier, the Fund aids in processing each claim but cannot overrule the findings of the carrier. In the event the insurance carrier rejects a claim, the claimant may request a review of the rejection. Such request for review is to be addressed in writing within 60 days of the notice of rejection to the insurance carrier and submitted to the CSA Retiree Welfare Fund office for forwarding. The Fund will assist and cooperate in obtaining a review and final decision by the carrier.

Where the benefit is not provided through an insurance carrier, and the claim is properly presented for processing, it is acted upon promptly and paid promptly. In the event that the Fund finds that the claim is incomplete or otherwise lacking in information, the claimant is promptly requested to furnish the necessary data. If a finding is made that the claim is improper or unjustified and is rejected, the claimant is notified of such rejection and the reason for such rejection is given. The claimant then has a right to request a review by submitting the request in writing, including the claimant's comments and the issues to be determined, to the Trustees of the Fund within 60 days of the date of rejection. In such event, the Trustees will review the claim at their next scheduled meeting and will render a decision following that meeting. The decision of the Trustees is final and binding on all parties.

# General Information Concerning the Organization of the Fund

The Fund is administered by a Board of Trustees. It consists of six persons designated by the Council of School Supervisors and Administrators of the City of New York Local 1, AFSA, AFL-CIO. Members of the Board of Trustees can be communicated with by contacting them through the Fund office. The Board of Trustees governs the Welfare Fund in accordance with an Agreement and Declaration of Trust. The Board of Trustees employs an Administrator who is responsible for the day-to-day operation of the Fund.

The Administrator of the Fund has been designated as the agent for the service of legal process at the Fund's office - 16 Court Street, 34th Floor Brooklyn, New York 11241. The Board of Trustees employer identification number is 11-2692902, the Plan number is 501(c)9. The fiscal year is October 1st to September 30th.

The Fund was established as a result of Collective Bargaining between the Council of School Supervisors and Administrators of the City of New York, Local 1, AFSA, AFL-CIO and the Department of Education of the City of New York located at 65 Court Street, Brooklyn, New York 11201. Contributions are predicated on the amount stipulated in the Collective Bargaining Agreements. Contributions are provided at annual rates, prorated monthly on behalf of each covered retiree. Retirees do not contribute. The Fund's assets and reserves are held in custody and invested by the Board of Trustees through various investments, savings and commercial banks.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies.

Dentcare (Healthplex) and Delta Dental underwrite prepaid Dental Programs described in this booklet.

All other benefits are self insured by the CSA Retiree Welfare Fund.

As someone who is eligible for benefits from this plan, you are no doubt aware of the fact that the benefits are paid in accordance with plan provisions out of a trust fund which is used solely for that purpose. If you have had any questions or problems as to benefit payments, as always, you have the right to get answers from the Trustees who administer the Fund.

As a participant in the CSA Retiree Welfare Fund, you are entitled to certain rights and protection provided by the Fund.

• You can obtain copies of all reasonable and appropriate plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

• You can receive a summary of the plan's financial report. The plan administrator will furnish each participant with a copy of the Fund's Summary Annual Report.

In addition to creating rights for plan participants, the Fund's trust agreement imposes duties upon the people who are responsible for the operation of the retiree benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under the trust agreement.

If your claim for a welfare benefit is denied in whole or in part, you will receive an explanation of the reason for the denial. You have the right to have the Fund review and reconsider your claim. If you are still dissatisfied, the Fund's supplementary agreement provides for resolution of such disputes through an arbitration procedure.

This booklet constitutes the plan of benefits of the Council of School Supervisors and Administrators Retiree Welfare Fund and, as such, includes the specific terms and conditions governing the coverage and the benefits provided by the Fund. In addition, there are various administrative policies and procedures which are applied on a uniform basis by the Fund and claimants will be informed whenever such policies and procedures are applied.

While this booklet describes the general features of the CSA Retiree Welfare Fund program for your information, it is not to be deemed a contract of insurance. The specific terms and conditions governing your coverage are set forth in the certificates of each basic plan. Where a specific program is not covered by insurance, your benefit programs are controlled by the rules and regulations of the CSA Retiree Welfare Fund then in effect.

# Plan Interpretations and Determinations

This booklet describes the main features of our plan. The Board of Trustees is responsible for interpreting the plan and for making determinations under the plan. In order to carry out their responsibility, the Board of Trustees, or their designee, shall have exclusive authority and discretion to: determine whether an individual is eligible for any benefits under the plan; determine the amount of benefits, if any, an individual is entitled to from the plan; interpret all of the provisions of the plan; and interpret all of the terms used in the plan. All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under the plan; be given deference in all courts of law to the greatest extent allowed by applicable law; and not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith.

# Statement of Privacy Practices IN COMPLIANCE WITH HIPAA PRIVACY REGULATIONS

***NOTICE OF PRIVACY PRACTICES***

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

***This Notice is effective on July 1, 2010.***

This Notice applies to the health benefits provided under the following health plan{s} (the "Plan{s}") sponsored by ***CSA Retiree Welfare Fund.***

***CSA Retiree Welfare Fund Supplemental Benefits***

The references to "we" and "us" throughout this Notice mean the Plan{s}. This Notice has been drafted to comply with the "HIPAA Privacy Rules", under federal law. Any terms that are not defined in this Notice have the meaning specified in the HIPAA Privacy Rules. Please provide this Notice to your family.

## How We Protect Your Privacy

We are required by law to protect the privacy of your protected health information and to provide you with this notice of our privacy practices. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan{s}, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

We maintain confidential information and have procedures for accessing and storing confidential records. We restrict internal access to your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

# How We May Use and Disclose Your Protected Health Information

We will not use your confidential information or disclose it to others without your written authorization, except for the following purposes. When required by law, we will restrict disclosures to the Limited Data Set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

• ***Treatment.*** We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

• ***Payment.*** We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan{s}. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.

• ***Health Care Operations.*** We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

• ***Disclosures to the Plan Sponsor.*** The Council of School Supervisors and Administrators is the Plan sponsor. We may disclose your protected health information to the Plan sponsor. The Plan sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan{s}. The Plan sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan{s}, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan{s} and it will not use protected health information for any employment-related actions or decisions. The Plan{s} may also disclose enrollment information to the Plan sponsor. The Plan{s} may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan{s}.

• ***Disclosures to Business Associates.*** We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

• ***Disclosures to Family Members or Others.*** Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest.

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## How We May Use and Disclose Your Information CONTINUED

After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

• ***Other Uses and Disclosures.*** The law allows us to disclose protected health information without your prior authorization in the following circumstances:

• ***Required by law.*** We may use and disclose your protected health information to comply with the law.

• ***Public health activities.*** We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

• ***Reports about victims of abuse, neglect or domestic violence.*** We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

• ***To health oversight agencies.*** We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

• ***Lawsuits and disputes.*** If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

• ***Law enforcement.*** We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

• ***Coroners, medical examiners and funeral directors.*** We may disclose protected health information to facilitate the duties of these individuals.

• ***Organ procurement.*** We may disclose protected health information to facilitate organ donation and transplantation.

• ***Medical research.*** We may disclose protected health information for medical research projects, subject to strict legal restrictions.

• ***Serious threat to health or safety.*** We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

• ***Special government functions.*** We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

• ***Workers' compensation or similar programs.*** We may disclose your protected health information when necessary to comply with worker's compensation laws.

## Uses and Disclosures With Your Written Authorization

We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice, without your written authorization. For example, we will not (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations), (2) sell your confidential information (unless under strict legal restrictions), or (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

## Your Individual Rights

You have the following rights:

Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself

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# Your Individual Rights CONTINUED

or a designated individual.

If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

• Was not created by us, unless the person who created the information is no longer available to make the amendment;

• Is not part of the protected health information we keep about you;

• Is not part of the protected health information that you would be allowed to see or copy; or

• Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

Right to obtain a list of the disclosures. You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2003. The list we provide will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period.

You may also request and receive an accounting of disclosures of electronic health records made for payment, treatment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009, or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out-of-pocket.

## Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to the Privacy Officer listed below. The Plan{s} will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

## Future Changes to Our Practices and This Notice

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Privacy Officer.

## Contact Information

CSA Retiree Welfare Fund
Douglas V. Hathaway, Ph.D., Privacy Officer
16 Court Street, 34th Floor
Brooklyn, NY 11241
(718) 624-2600
dhathaway@csawf.org

# Administrative Fees

## Returned Mail

It is the member's responsibility to inform the Fund of address changes in a timely fashion. Each year hundreds of checks and other correspondence are returned to us because of invalid addresses. If you are routinely at an alternate address, please complete the available alternate address form and return it to the Fund. Notification of changes in address made to other organizations, such as the CSA Retiree Chapter, Teacher's Retirement System, or the City health plan in which you are enrolled does not automatically change your address with the Fund. As a result, there is a $2.00 charge for each piece of mail returned to the Fund.

## Miscellaneous Charges

Members will be held responsible for bank charges for checks returned due to insufficient funds, stop-payment orders, etc.

# Caution

This booklet and written material from the Trustees and the Fund's office personnel are your only authorized sources for plan information for you.

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# Notes

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