Health Benefits Program

CSA
WELFARE
FUND

BENEFIT BOOK ACTIVE MEMBERS JAN.1, 2012 EDITION

CSA WELFARE FUND

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Contents

Message From the Chairperson of the Board of Trustees

Dear Colleague:

This CSA Welfare Fund benefit booklet describes in detail the benefits provided to you with the monies made available to the Fund through the collective bargaining agreement between our Union and the Department of Education.

As you read this booklet, you will find that your Trustees have developed a comprehensive benefit program designed to fill gaps in the City provided health plan that you have chosen as well as a number of benefits designed to enhance your coverage.

The Fund provides benefits not provided by the City Health Plan such as optical, hearing aid, dental, prescription drugs and life insurance coverage. In addition, the Fund provides benefits such as coverage for surviving dependents and extended benefits such as the cost of private duty nursing and appliances.

Most importantly, the Fund protects each member and their eligible dependents against catastrophic medical costs by providing stop-loss protection. This stop-loss coverage assures protection against excessive, unreimbursed, out of pocket expenses.

We take pride in the fact that this multi-faceted CSA Welfare Fund benefit program contains a broad application of coverage to members. The Fund is also proud of its reputation for dedicated, prompt and courteous service to its members.

On behalf of the staff and Trustees of the CSA Welfare Fund, I assure you that we stand ready to serve and assist you should you need our help.

Sincerely,

Ernest A. Logan
Chairperson
Board of Trustees

Forward

The Trustees of the CSA Welfare Fund are proud of the benefit program that has been developed over the years to provide our members with comprehensive protection from rising medical costs.

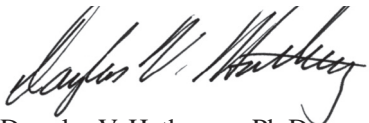
The program developed by the Trustees is unique in that it has been designed to provide members with choices. There is a choice of dental plans, where a member may select a plan which allows access to any dentist or a plan which requires only use of a participating dentist. Optical services are available either from participating providers or through providers of the member's own choice.

The program also provides, through its catastrophic stop-loss benefit, a “safety-net” to protect members and eligible dependents from major health related expenses. In virtually all cases an individual’s out-of-pocket cost is limited to $1,750 per year (based on allowable charges), with the Fund reimbursing the remainder.

The Fund's benefit program is also unique in that it provides benefits not normally provided by other union health funds, such as continued protection for surviving dependents of members who die in service.

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, forwarding 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, and by using participating providers where possible and submitting claims in a timely fashion.

The staff of the CSA 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 job. 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.



Douglas V. Hathaway, Ph.D.,
Administrator

General Information

Eligible Members

All employees of the Department of Education of the City of New York who are employed by appointment or assignment under license or other pedagogical certification in a supervisory or administrative capacity, and who are covered under collective bargaining agreements between the CSA and the Department of Education, or who are designated for coverage by agreement with the Department of Education and for whom contributions are made on a regular basis by the Department of Education to the CSA Welfare Fund, and employees of the Union and/or the Fund for whom contributions are made on a regular basis by the Union and/or the Fund are eligible for the benefits described in this booklet. Eligibility ceases upon termination of such employment and the cessation of contributions, except in certain situations, described later, for a member on leave for personal illness or special circumstances.

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 Welfare Fund benefits except death benefits. Dependents, as defined by the Fund, are the legally married spouse (or registered Domestic Partner) eligible for coverage by the City-provided health benefits program; unmarried dependent children who have not reached their 26th birthday and do not have health benefits through his/her employer, and 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.

An ex-spouse is never eligible for coverage regardless of the provisions of any legal settlement.

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 to physical, psychiatric or other examination or evaluation.

Eligibility as a handicapped child is also dependent upon 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 child under 26 years of age who is 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.

Coverage by the Fund for benefits which are supplemental to the City health plan is dependent upon the dependent's eligibility for coverage under the City plan. Dependents not covered by the City plan will not be covered by this plan.

The Fund requires certification at the beginning of each plan year that a covered dependent who has not attained his/her 26th birthday remains eligible for coverage. Failure to provide required certification of continued eligibility may result in termination of eligibility for the dependent.

Domestic Partners

The Trustees have adopted the City health plan definition of, and coverage for, domestic partners as defined in the New York City Summary Program Description booklet.

Members who wish to apply for coverage for a domestic partner may obtain details concerning eligibility, enrollment, and tax consequences from the New York City Office of Labor Relations, Domestic Partnership Liaison Unit at (212) 306-7336.

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. Documentation showing City coverage for the domestic partner and registration with the Domestic Partner Registry should be forwarded to the Fund when applying for Fund coverage.

The Fund is required to provide the New York City Office of Labor Relations each year with a list of members who provide Welfare Fund benefits to a Domestic Partner. This amount, based on the current COBRA contribution, is reported as other income on the member's W-2.

Enrollment

All new members must complete a CSA 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 bonafide relationship of any dependent to the member (e.g. a birth certificate, marriage license, domestic partner registration, etc.)

Suspension of Benefits

The Fund reserves the right to deny or suspend benefits to members and/or their dependents when appropriate documentation of eligibility of the member or dependent is not provided to the Fund in a timely fashion. Benefits may also be suspended if monies are paid by the Fund for an ineligible member or dependent and is not reimbursed to the Fund in a timely fashion. If a member does not make timely payment of required co-payment amounts for Fund-provided benefits, such as, but not limited to, mail-order prescription drug co-payments, benefits may also be suspended until such time as all co-payments have been paid.

Eligibility for CSA Welfare Benefits

When You Are Covered:

You will be eligible for the personal and dependent benefits described in this booklet if you meet the requirements as an eligible member, or dependent as defined earlier.

Deferred Effective Date of Insurance:
PERSONAL COVERAGE:

If you are absent from active full time work for any reason other than authorized vacation, on the date you would otherwise become insured for personal coverage, the effective date of your personal insurance will be deferred until the date on which you return to active full time work.

Dependent Coverage

If a dependent is confined in a hospital on the date benefits would otherwise become effective, the effective date of the coverage with respect to the dependent will be deferred until the dependent is discharged from the hospital.

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 Welfare Fund if the young adult is unable to attain comprehensive coverage from his/her 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.

Termination Date of Benefits

FOR MEMBERS: PERSONAL COVERAGE

Your personal coverage will terminate on the earliest to occur of the following dates:

- The date on which you terminate employment or are terminated from active pay status (If you should be unable to work because of disability or you are on a leave of absence without pay for reasons of health, see that section.)
- The date you cease to be in a group of members eligible for coverage under this program of benefits

FOR DEPENDENTS

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.

FOR YOUNG ADULTS AGE 26 PLAN

Coverage with respect to young adults will terminate on the earliest to occur of the following dates:

- The date the young adult becomes ineligible for coverage under the member's City health plan.
- The end of the month in which the young adult reaches his/her 26th birthday.
- The date on which the member's eligibility terminates except in the case of Survivors Benefits.
- The date on which the young adult is eligible for benefits through his/her employer

Extension of Coverage

Authorized Sick Leave Without Pay (SLOAC)
(Special Leave of Absence Coverage)

After the member has exhausted his/her sick leave and is on authorized sick leave without pay, or on, an approved maternity leave, the member and eligible dependents will remain fully covered by the City provided health plan for 4 months. The CSA Welfare Fund (except in the case of a maternity leave) will continue the coverage of the City plan for an additional 8 months and will also provide full coverage for all Welfare Fund benefits for up to one year, provided the member remains on authorized sick leave and submits satisfactory proof of such leave.

Family Medical Leave Act (FMLA) of 1993

Eligible employees may receive up to 12 weeks of continued coverage in a 12 month period, for both their City health plan and Welfare Fund benefits, if they are placed on an approved unpaid leave for the following reasons:

- To care for the employee's child after birth or placement for adoption or foster care.
- To care for the employee's spouse, parent or child who has a severe health condition.
- For a serious health condition that does not allow the employee to perform the employee's job.
- By special action of the Board of Trustees

Pedagogical employees must submit advance leave notice and medical certification to their payroll secretary or human resources office.

Retirement

If you retire and receive a New York City pension, you and your eligible dependents can continue your health plan coverage without additional cost. The City of New York will continue to pay the cost of the premium. You may wish to choose the optional benefits rider offered by your City health plan, the cost of which will be deducted from your pension check. The supplementary benefits provided by the CSA Welfare Fund will not be continued. You will instead be eligible for additional benefits provided by the CSA Retiree Welfare Fund. You are advised to contact the Fund for clarification of your eligibility for such coverage.

Your Right to Continuation of Coverage (COBRA)

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. You are permitted to purchase the coverage provided for up to 18 months when termination of your coverage is due to termination of your employment for reasons other than gross misconduct (in some cases in New York State this period maybe extended to 36 months). Your dependents are also 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 becomes covered under another group health plan. See "Survivor Benefits" section.

Members are advised that if they wish to have continued coverage for themselves and/or any of their eligible dependents, they must notify their time keeper as well as the Fund, should any of the following circumstances occur:

A: The member's job is terminated and no further contributions for coverage will be provided to the Fund by the employer.
B: The member and spouse become legally separated or divorced.
C: A dependent child has reached his/her 26th birthday. The time keeper will provide the member with a COBRA application and explanatory material.

Upon notification to the Fund, 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 are eligible for coverage. If an application is not filed within that period of time, the Fund may not be able to offer such optional paid coverage.

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* See “Survivor Benefits” section

** Federal COBRA rules do not apply for Medicare-eligible members. However, as a result of a collective bargaining agreement, the City of New York and the unions representing municipal employees have agreed to provide COBRA coverage to Medicare-eligible members and their dependents.

Young Adult Coverage Through Age 29

The Fund voluntarily complies with New York State legislation which allows young adults through age 29 to obtain coverage. 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 NYState 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. In 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 Plan 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 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.

Non-Duplication of Benefits

The purpose of the basic City health insurance program, as well as the CSA 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 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 different plans, but one may not cover the other as a dependent and all children must be enrolled with the same parent.

Coordination of Benefits

All benefits provided by the CSA Welfare Fund are subject to Coordination of Benefits (COB) provision. COB is applicable when you or your dependents are covered by another group benefit plan. Benefits are then payable under a primary secondary formula.

The primary plan determines its benefits first, and pays its normal benefit. The secondary plan computes its benefit second, and may reduce its benefit payment so that the insured does not receive more than 100% reimbursement of expenses based on reasonable and customary costs. In no event would the CSA Welfare Fund's liability exceed the benefits payable in the absence of COB.

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;
   a. The plan of the parent whose birthday falls earlier in the year provides primary coverage.
   b. If both parents have the same birthday, the plan which has been in effect the longest is primary.
   c. 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 special rules concerning dependents of separated or divorced parents.)
3. If no other criteria apply, the plan covering you the longest is primary. However the plan covering you as 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.

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, the benefits of that parent's plan are determined first. You must provide the appropriate plan with a copy of the portion of the court order showing responsibility for health care expenses of the child.

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.

NOTE: Whenever the CSA Welfare Fund has made payments 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.

No Fault Insurance

The Fund will not pay any benefits that are covered by the New York State or another jurisdiction's No Fault Insurance Law.

Medicare and City Coverage

Since 1981, Medicare has become the secondary payer of benefits for an increasing number of active employees and their dependents. This trend of making the City coverage primary and Medicare coverage secondary (TEFRA, DEFRA, COBRA) has continued with the signing of the Omnibus Budget Reconciliation Act (OBRA) into law. As a result of TEFRA, DEFRA and COBRA, the City must offer all active employees and their spouses, regardless of age, the same health insurance coverage it offers to all other eligible employees. Under OBRA, the City's health plan becomes the primary payer for any disabled employee or dependent, regardless of age. OBRA, effective January 1, 1987, allows any disabled employee or dependent of a City employee to elect the City's health program as primary coverage. Medicare coverage would become secondary. Active employees with dependents covered by Medicare Disability may maintain secondary coverage through Medicare if they desire. Individuals electing Medicare coverage as primary coverage under the provisions of TEFRA, DEFRA, COBRA, or OBRA waive their right to coverage under the City's health program.

NOTE: There is one exception: Under OBRA, if the disabled person is on dialysis, Medicare will remain primary, with the City health insurance staying secondary. Employees should contact their present health insurance carrier to assure that their coverage remains this way.

Since the CSA Welfare Fund medical benefit program is supplementary to the City plan, members are advised that such benefits from the Fund will also be discontinued for those who choose Medicare as the primary insurer. The Fund will continue to provide those benefits that are not supplemental to the City plan such as dental benefits, prescription drugs, life insurance, optical benefits and hearing aid benefits.

Enrollment in Medicare Part B through the Social Security Administration is now voluntary for employees and their spouses affected by these laws. There are no longer any penalties for late enrollment due to coverage under TEFRA, DEFRA, COBRA, or OBRA.

Retiring employees over 65 or whose spouses are over 65, are permitted to change plans at the time of retirement because Medicare will then become primary and the City plan becomes secondary.

General Limitations and Exclusions to Welfare Fund Benefits

Coverage under the CSA 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 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;
- Treatments which exceed the limit in the number of treatments established for that service.

The Fund reserves the right to suspend benefits to members and their dependents if documentation required by the Fund to establish eligibility for benefits for members and/or dependents is not provided in a timely fashion. Benefits may also be suspended if monies paid by the Fund for ineligible claims, is not reimbursed to the Fund in a timely fashion.

The Fund reserves the right to recover funds reimbursed to members, or their eligible dependents, for medical expenses that are incurred as the result of accident or injury that are later retrieved by the member or eligible dependent as an award through legal action or other insurance compensation.

Life Insurance Benefits

(INSURED BENEFIT PROVIDED BY GUARDIAN INSURANCE COMPANY)
(Members only, not applicable to dependents)

Death Benefit

A life insurance benefit will be paid in a lump sum to your beneficiary in the event of your death. The benefit is $ 10,000.

Beneficiary

You may name anyone you desire as your beneficiary and you may change your beneficiary at any time by giving written notice to the CSA Welfare Fund on the form which will be provided. It is the member's responsibility to ensure that he/she provides the Fund with updated beneficiaries. If a member dies while an active in-service participant in the Fund, a copy of the current enrollment card and beneficiary designation must be provided to the insurance company.

Hearing Aid Benefits

All members and their eligible dependents are covered for hearing aid benefits.

Benefits

A reimbursement of up to $600 is provided for the purchase of one hearing aid every thirty six months. The referral of a physician or an audiologist is required.

How to Obtain Benefits

Write, call the Fund office, or submit a request by emailing voucherrequest@csawf.org through the Fund's website requesting a hearing aid benefit claim form. Portions of the claim form must be completed by the member, the physician or audiologist and the hearing aid dealer. The completed claim form should be **signed** and 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 receipt, for the services provided.

You will also be provided with a listing of hearing aid providers who have agreed to provide our members with full hearing aid services at a reduced rate with a $35 co-payment required from the member. You may authorize payment directly to one of these providers, if you wish.

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.

Dental Benefits

All members and their eligible dependents are covered for dental benefits.

The CSA Welfare Fund provides members and their eligible dependents a choice of two different dental benefit programs. A dental schedule plan administered for the Fund by S. I. D. S. and the Dentcare HMO Pre Paid Dental Program administered by Healthplex.

The specific benefits provided under each of these programs are described in full in separate brochures (available upon request). Members are advised to read these descriptive booklets carefully and to make a choice as to which dental benefit program they wish to select for themselves and their eligible dependents.

The SIDS Dental Program—Option 1

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 reimbursed on the basis of a Schedule of Allowances that is described in a separate brochure. Your reimbursement is subject to the limitations in the schedule and maximum allowances.

c) 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, deductibles or maximum allowances listed in the "Schedule" for which the patient will be responsible.

Dentcare-Healthplex HMO Dental Plan for NY/NJ—Option 2

A pre-paid dental plan. Dentcare Dental Plan by Healthlplex 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. The Fund pays the total cost of this plan.

b) Upon enrollment in the plan, the member 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.

c) This 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 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.

e) Specialized dental care, such as endodontic, 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 coverage area, the cost for such care may be submitted to Healthplex for possible reimbursement. Reimbursement is generally limited to that needed to eliminate pain. Other services must be provided by a participating dentist.

If you are interested in enrolling in the Dentcare program, call the Fund for an enrollment form, descriptive materials, and listing of participating dentists.

You may enroll in either of the two plans listed above. If you do not submit an application for enrollment in the Dentcare/Healthplex HMO dental plan, 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

All members and their eligible dependents are covered for optical benefits.

Members have 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 for members and eligible dependents.

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 oversize 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 provider'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 as follows:

Single vision lenses and frame	$65
Bifocal and multi focal lenses and frame	$65
Single vision lenses only	$35
Bifocal or multi focal lenses only	$35
Frame only	$25
Contact lenses including all services	$65

How to Obtain Benefits

Write, call the Fund office, or submit a request by emailing voucherrequest@csawf.org through the Fund's website, requesting an optical certificate. Specify for whom the certificate is intended. Certificates are not transferable, are valid for 30 days from date of issue, and must be returned if not used. Provide your Social Security number when submitting your request.

A listing 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. Should you ***NOT*** use a participating provider, certificates must be completed, ***signed*** and returned to the Fund with a 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.

Laser Eye Surgery Benefits

*The Fund will include as a covered expense a **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 Welfare Fund members and will accept payment of the benefit directly from the Fund. Members may also 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, call the Fund office, or submit a request by emailing voucherrequest@csawf.org through the Fund's website 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 claim form should be returned to the Fund office for processing and payment. The claim form must be accompanied by a proof of payment such as an itemized paid, receipt 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.

In-Patient or Out-Of-Hospital Psychiatric Benefits

Members enrolled in a New York City health plan are provided with out of hospital psychiatric benefits for themselves or their eligible dependents in the basic benefit program. The Fund does not provide separate or supplemental coverage for this service.

Prescription Drug Benefits

All members and eligible dependents are covered for prescription drugs through the CSA Welfare Fund Prescription Drug Plan administered by MEDCO up to a maximum of $15,000 per patient per calendar year.

This benefit provides three ways for you to obtain prescription drugs as follows:

Obtain Drugs Through Your Participating Neighborhood Pharmacy

You will be issued a plastic drug card, which can be used at any participating pharmacy nationwide. Cards reissued to a member due to loss or breakage may require a $5 fee for replacement.

In order to provide security when prescriptions are submitted, the name, date of birth and sex of the patient must be clearly indicated on the prescription. Drug cards only contain the name of the member. Eligible dependents will be covered even though their name may not appear on the card. That is why date of birth, sex and patient name will be required when prescriptions are filled.

MEDCO is a nationally recognized pharmacy benefits manager. You will find pharmacies across this country who will be eager to accept this plan. The Fund can be contacted for referral to a participating MEDCO Pharmacy in your geographic area.

There is an annual $50 per person / $150 per family deductible for medications purchased at a local pharmacy. After the deductible has been satisfied, participants pay 10% of the discounted cost of generic medications, 25% of the discounted cost of brand-name preferred medications, and 35% of the discounted cost of non-preferred brand name medications.

Mandatory Mail Service For Maintenance Medications

If a medication is classified as a maintenance medication, one which will be taken for an extended period of time, you may obtain the original prescription and 2 refills at the local pharmacy, after which you must use the mail-order program for maintenance medications. Refills beyond the specified number will result in the participant paying 100% of the cost of the medication. Those medications which must be taken immediately, or which must be monitored as to efficacy, are not subject to the requirement for mail-order participation.

Chronic or Maintenance Drug Plan

You must utilize our mail order drug plan, MEDCO by Mail, to obtain long term maintenance drugs for chronic medical conditions.

The mail order program for members with chronic conditions requiring long term drug utilization will not be subject to the annual $50 per patient deductible. Mail order prescriptions will require a $10 co payment for generic drugs, a $25 co-payment for preferred brand name drugs, and $35 for non-preferred brand-name medications for a 60 day (2 month) supply permitting up to 5 refills, if prescribed by the doctor, before a new prescription is required. You must utilize a special mail order prescription form.

A toll free number is available for you to use to get immediate answers to your questions regarding your prescription.

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Prescription Drug Benefits (CONTINUED)

Direct Reimbursement

Should you, for any reason, have to pay for your drugs because you did not have your drug card or you used a non participating pharmacy, you may submit your itemized bill to MEDCO utilizing a special direct reimbursement form. The claim will be processed and you will receive the same reimbursement that the pharmacist would have received had the claim been processed through the regular plastic card procedure. Limits on amounts dispensed and refills are the same as described above for drugs obtained from Neighborhood Pharmacies.

Limitations

Please be advised of the following limitations of the prescription drug program:

- The drug plan covers only prescription drugs required to preserve life. Prescription drugs prescribed for cosmetic purposes are not covered. Drugs such as wrinkle removers, hair restorers or drugs used to change smoking habits are also not covered.
- Drugs that are available in over-the-counter form, regardless of strength variations will not be covered. Examples of such drugs are Pepcid, multi-vitamins (Berocca), benzoyl peroxide (Clearasil or Benzagel). Certain anti-inflammatory drugs and H2 antagonists may be made available through the mail away program after medical necessity is determined, on a case-by-case basis.
- Needles, syringes or other companion implements, as well as appliances or medical supplies, are not covered by the drug plan. Expenses incurred for such materials may be submitted to your basic City provided health plan such as GHI, or to the Fund for possible coverage by the City health plan or the Fund.
- Prescription drugs (oral or injectible) required to treat diabetes are covered by the basic City health plan in which you are enrolled, not the Fund. Also covered by the basic City plan are syringes, needles, test strips and blood sugar measuring devices. Contact your health insurance carrier to obtain these drugs and materials. The Fund will consider your co payment costs, if any, charged by your health insurance carrier for drugs or syringes required for the treatment of diabetes as a covered expense under the Fund's Supplemental Medical Benefits Program under the Coordination of Benefits rule.

The PICA program, which is a jointly-administered program with the Municipal Labor Committee and the City Office of Labor Relations, provides two types of prescription drugs. Injectible and Chemotherapy medications are provided by this program, administered by Express Scripts. Members are advised to contact Express Scripts for the latest co-payment and coverage information. Costs for outpatient chemotherapy administered at a covered hospital will be provided by Blue Cross and should be billed by the hospital to Blue Cross. Chemotherapy treatment costs provided in a doctor's office, as well as, other doctor and professional charges should be submitted to your basic City-provided health plan.

Maximum Coverage

Prescription drugs are covered up to a maximum of $15,000 per patient per calendar year. This maximum applies to all drug costs paid by the Fund through the mail order, local pharmacy or direct reimbursement program.

Survivors Benefits

Economic readjustment following a member's death is a source of major concern. In almost all plans, family member benefits terminate. The CSA Welfare Fund provides continued coverage for Dental, Optical, Prescription Drugs, Hearing Aid and Supplemental Medical Benefits, without payment of any premium, for your surviving spouse and eligible dependents until the earliest of the following:

- Five years from the date of the member's death;
- Remarriage of the surviving spouse, in which case the coverage for all dependents terminates;
- The date a surviving spouse qualifies for Medicare (there is no benefit extension for a spouse who is already eligible for Medicare when the member dies). Coverage will be continued for eligible dependent children during the five year maximum survivor benefit period.
- The date a child ceases to qualify as a dependent (attainment of age 26). Continuation for dependent children will not be affected by the death of the surviving spouse during the five year maximum survivors' benefit period.

Important Note

The CSA Welfare Fund Survivors' Benefit will continue provided certain requirements are met as follows:

1. If the surviving spouse is a City employee or retired City employee and is eligible for City coverage but is covered as a dependent of the CSA member's plan, the surviving spouse must transfer the plan to his/her name, including coverage for dependent children. The CSA Welfare Fund will then continue supplemental coverage on the basis of the plan carried by the surviving spouse. Benefits available through any other welfare fund covering the surviving spouse will be primary under coordination of benefits with the CSA Welfare Fund benefits.
2. If the surviving spouse is a City employee and carries the City coverage in his/her name, including dependent children, with the CSA member listed as a dependent, the CSA Welfare Fund will then continue supplemental coverage on the basis of the plan carried by the surviving spouse. Coordination of any other applicable welfare fund coverage as mentioned above will also apply.
3. If the surviving spouse is unemployed, or if employed but has no coverage provided by their employer, the Fund will reimburse the COBRA premium available to the survivor through the City health plan insurance carrier for a period of 24 months from the date of the member's death.
4. If the surviving spouse is employed and has coverage from that employer for their eligible dependents which is equivalent to the coverage available from the City plan, the surviving spouse and eligible dependents will continue to be eligible for the other Survivors' Benefits provided by the CSA Welfare Fund.

Proof of coverage as described above must be submitted to the Fund.

***Excluded** from Survivors' Benefits are Life Insurance benefits.*

Health Benefits Buy-Out Waiver Program

The City offers a financial incentive to employees who waive their basic New York City health benefits coverage under certain conditions. This program allows City employees who are covered under their spouse's (partner's) health insurance or through another employer to waive their City health benefits and receive an annual incentive payment. Employees waiving family coverage are eligible to receive $1,000 and those waiving individual coverage are eligible to receive $500. Incentive payments will be taxed. Employees may apply for the Buy-Out Waiver Program during the transfer period, upon commencement of employment, or at a mid-year qualifying event.

- Payment of financial incentives will be made semi-annually and is included in the employee's regular paycheck.
- Those in the BOWP are not eligible for COBRA or SLOAC.
- Employees cannot participate in the BOWP if they are covered under a spouse/domestic partner who is also a City employee or retiree
- Employees cannot waive their family contracts to be covered under an individual contract and qualify for the BOWP
- Retirees are not eligible
- Coverage by the CSA Welfare Fund will not include benefits that supplement waived City coverage, such as supplemental medical and catastrophic medical. Coverage will be limited to prescription drugs, dental, optical, hearing aid, life insurance and survivor benefits only.

Change in Plan – Annual Transfer Period

Health insurance transfer periods are usually scheduled once each year. During these periods, all active employees are eligible to transfer from their current health plan to any other plan available or to select optional benefit riders.

To change your insurance plan during the transfer period, you must submit a new application form available at your payroll or personnel office. Once you exercise your right to transfer by submitting an application form during the transfer period, the transfer period is over for you.

If you do not apply for an Optional Benefits Rider when you first enroll, you may obtain these additional benefits only during a transfer period, upon retirement, or if there is a change in your Union or Welfare Fund coverage.

Major Medical Benefits

General Description

The CSA Welfare Fund receives monies from the City to provide benefits supplemental to and apart from the City provided coverage. The amount of monies received is determined by negotiations with the City and the Department of Education by your CSA Union.

The Trustees of your CSA Welfare Fund determine the benefits to be provided.

Members/Eligible Dependents Enrolled in GHI/CBP and Blue Cross

Hospitalization

Your basic hospitalization coverage has been extended to 365 full days in semi private accommodations. There is a separate deductible of $300 per admission with a $750 per person, per calendar year maximum established by Empire Blue Cross Blue Shield for hospitalization.

Hospital charges for non emergency outpatient treatment and ambulatory surgery are covered at 80% of approved charges. The subscriber is responsible for 20% of the charges up to $200 in a calendar year. This does not apply to emergency care for sudden and serious illness (subject to a $50 co pay if not admitted), pre surgical testing, hospice care or air ambulance services to hospitals in connection with an emergency situation when no other transportation is available.

Inpatient benefits for mental and nervous disorders and chemical dependency are covered by GHI and are described in detail in the New York City Health Benefits Summary Program Description as are the additional benefits which can be purchased in the optional benefits rider.

Emergency Room Physician Coverage

Emergency physician services (non-specialists) and non-invasive cardiology, radiology, and pathology services rendered in the emergency room of a hospital will be covered by Empire Blue Cross Blue Shield, provided the emergency room treatment is payable by Empire Blue Cross Blue Shield.

Services performed by consulting specialists/private physicians are not considered covered under this benefit. Services for these specialists/private physicians will be covered by GHI, subject to current plan deductibles and/or co-payments.

Skilled Nursing Facility/Rehabilitation Benefits

A maximum of 90 days coverage for Skilled Nursing Facility Care in an Empire Blue Cross Blue Shield participating facility, including 30 days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine is provided. To be eligible to receive benefits, subscribers must contact NYC Healthline at 1-800-521-9574 prior to admission.

The combined Skilled Nursing Facility/Physical Rehabilitation Benefit allows coverage for up to 90 days per calendar year. Inpatient hospital stays primarily for the purpose of physical therapy, physical medicine, physical rehabilitation, or a combination of these services are counted toward the skilled nursing facility benefit.

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Major Medical Benefits (CONTINUED)

Cardiac Rehabilitation Benefit

Cardiac Rehabilitation through Empire Blue Cross Blue Shield's participating network facilities is available for select cardiac conditions. This benefit provides up to a maximum of 12 weeks rehabilitation or 36 visits subject to prior approval. To be eligible to receive benefits, subscribers must contact NYC Healthline at 1-800-521-9574. Upon approval, NYC Healthline will provide the necessary referral to an Empire Blue Cross Blue Shield participating Cardiac Rehabilitation Facility.

Medical/Surgical Care

The GHI Comprehensive Benefits Plan provides two forms of coverage combined in one plan. Subscribers receive paid in full benefits when they choose care from one of GHI's participating physicians and other health care providers. All of these physicians and providers have agreed to accept GHI's allowances as payment in full. Payment for covered services is made directly to the participating provider. Home and office visits and out of hospital specialist consultations are subject to a $15 or $ 20 co payment charge, depending upon the provider.

When you are unable to use the services of a participating provider, GHI also covers the services of non participating providers. Payment for these services is made directly to you under the New York City Non Participating Provider Schedule. Payment is subject to yearly deductibles ($200 per person, maximum $500 per family), and a lifetime benefit maximum ($2 million per person). Payment is made at 80% of the New York City Non Participating Provider Schedule.

After you incur $1,500 or more in covered expenses (as determined by GHI), GHI reimburses you at 100% of the GHI Schedule.

GHI has developed a network of high quality medical institutions to provide a broad range of cardiac care and heart transplant procedures. When subscribers utilize services at these "Centers of Specialized Care", they will receive paid in full benefits without deductibles or co insurance, thereby saving significant out of pocket expenses.

A separate GHI preferred provider panel has been established to supply durable medical equipment (subject to a separate annual deductible of $100 per person). There will be no out of pocket expense other than the deductible. If you obtain durable medical equipment from other than preferred providers, GHI will reimburse you at 50% of the allowed charges.

CSA Supplemental Coverage

The CSA Welfare Fund provides supplemental coverage which will extend your coverage for the following services which are limited by GHI if the Fund independently finds such services to be necessary. Reimbursement for these services will be at 80% of reasonable and customary charges after a separate annual deductible of $150 per person or $450 per family to $2,000 in payment.

1. Reimbursement of expenses for emergency ambulance services not fully reimbursed by the City basic health plan. Ambulance services coverage is limited to emergency services to a hospital. No other ambulance or ambulette services are covered.
2. 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 $400, with a maximum of two sets of orthotic devices per patient during a calendar year. This limitation is in addition to the general limitation of the $2,000 maximum payment per calendar year for all medical services covered.
3. 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 of wigs is limited to a maximum of $1,000 per year. This limitation is in addition to the general limitation of the $2,000 maximum payment per calendar year for all medical services covered.
4. Physical therapy, speech therapy, and acupuncture treatments performed by an MD, 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 16 such treatments, the Fund will cover an additional 4 treatments.
5. Chiropractic care is included in all City health plans. Members obtain these services solely through the City health plan in which they are enrolled.

Optional Benefits Program

The City provided GHI CBP Blue Cross plan offers certain optional benefits which may be purchased by City employees. These additional benefits are described in detail in your City benefit booklet. Since the CSA Welfare Fund provides prescription drug coverage, members of the CSA Welfare Fund who are the certificate holders of the City plan for GHI/BC are not provided this benefit in their rider if selected and are not charged for this benefit in the cost of the rider.

The CSA Welfare Fund provides the following:

Catastrophic Stop-Loss Coverage

In addition to the above listed coverage, the CSA Welfare Fund provides Stop-Loss Protection. 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 $1,500 for an individual or $4,500 for a family, for covered services, the Fund will provide reimbursement of any such excess expense at 80% until it has paid $1,000; thereafter, reimbursement will be made at 100%. 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 or Blue Cross (not the co payment charges when using participating providers). In effect, a member or eligible dependent will incur no more than $1,750 in out of pocket unreimbursed expenses, and no family will incur expenses greater than $4,750 during any calendar year, subject to the maximum benefit limitation described below, provided these expenses are for necessary covered services and are considered by the Fund to be reasonable and customary charges.

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Optional Benefits Program (CONTINUED)

Maximum Benefit

The Fund's maximum benefit per member or eligible dependent for reimbursement of medical expenses including catastrophic stop loss coverage is limited to $50,000 in any calendar year and has a lifetime limit of $250,000. This is in addition to GHI CBP coverage of $2,000,000.

Filing of Claims

All claims for coverage provided by Blue Cross are filed directly with Blue Cross.

All claims for coverage provided by GHI CBP are filed directly with GHI CBP. Claim forms are provided by GHI CBP and must be filed with GHI within 90 days after the end of the calendar year in which services are rendered.

All claims for coverage provided by the CSA Welfare Fund are filed directly with the Fund. Members should contact the Fund to request the appropriate claim forms. The Fund will not be liable for reimbursement of expenses rejected by GHI because of late or improper filing or for services not covered by GHI, except for those services specifically listed as covered expenses by the Fund.

Members/Eligible Dependents Enrolled in GHI Type C and Blue Cross

Coverage under this plan is not recommended as an appropriate choice for most members of the CSA Welfare Fund. This plan is an indemnity plan that makes payments for physician's bills based on a schedule of allowances which has not been materially revised or updated since 1974. This plan has been phased out as a benefit available from the City.

Members/Eligible Dependents Enrolled in HIP-HMO

HIP HMO provides unlimited hospitalization coverage and comprehensive medical coverage when such services are provided by HIP HMO medical group physicians. The details of your HIP HMO coverage are described in the City health plan booklet.

Supplemental Coverage Provided by CSA Welfare Fund

The CSA Welfare Fund provides to its members and their eligible dependents all of the optional benefits available for purchase as riders to the City provided benefit plan and also extends coverage to provide reimbursement for services which are not provided by the HIP HMO plan as follows:

Prescription Drugs

Prescription Drug Benefits are provided through MEDCO (see separate section for Prescription Drug Coverage).

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Optional Benefits Program (CONTINUED)

Private Duty Nursing and Appliances

Private Duty Nursing services provided by a registered nurse, or licensed practical nurse when an RN is unavailable, is a covered expense provided by the Fund to a maximum of $5,000 during any calendar year. Such services (in or out of hospital) must be justified as necessary care and ordered by a physician.

Necessary appliances, such as hospital beds and wheelchairs, and prosthesis, as well as orthopedic or orthotic devices for the feet and certain prosthetic appliances and equipment such as splints, casts and wigs required by patients undergoing chemotherapy and ordered by a physician, will be covered by the Fund. Appliances and equipment of a general nature, not specifically designed or fabricated specifically for the patient, such as ready made shoes, heating pads or exercise equipment, are not considered covered expenses.

Podiatric care, not of a routine nature, is provided by the Fund to a limit of 4 visits per year, if not provided by HIP.

The above listed services, which are excluded by the City provided coverage will be reimbursed at 80% after an annual deductible of $150 ($450 per family) to $2,000 in payment.

The Fund will provide reimbursement for the above services, equipment or appliances provided they are considered by the Fund to be necessary to the care of the patient and the costs are reasonable and customary.

Catastrophic Stop-Loss Coverage

Should a member or eligible dependent incur out of-pocket expenses for covered services not provided or fully reimbursed by HIP HMO in excess of $1,500 during a calendar year, the Fund will provide reimbursement for any expenses over and above $1,500, ***exclusive of hospital charges**** incurred. The Fund will reimburse such expenses at 80% until it has reimbursed $1,000. Thereafter, the Fund's reimbursement will be at 100%.

* It is important to note that charges made by a hospital for inpatient treatment, not arranged by or covered by HIP-HMO, will not be considered a service covered by the Fund. The Fund will not be responsible for reimbursement of such hospital expenses.

Total coverage for both the supplementary major medical benefit described above and the Catastrophic Stop-Loss Coverage will be limited to a total of $50,000 during a calendar year and $250,000 lifetime per person for expenses that are reasonable and customary and are considered by the Fund to be for necessary care and treatment.

Members/Eligible Dependents Enrolled in Other HMO Plans

Members are advised to read the City Summary Program Description booklet describing other health plans and their corresponding extended coverage riders which are available to City employees. Since all of the current additional health plans being offered are similar in design to HIP HMO, members are advised that the supplemental benefits provided by the CSA Welfare Fund to members and their eligible dependents who enroll in any of these other plans, will correspond as closely as possible to those benefits which are provided by the Fund to members and their eligible dependents who are enrolled in HIP HMO.

Members are advised to call or write the Fund for clarification of the Fund's supplemental medical coverage relative to the specific City health plan in which the member is enrolled, or is planning to enroll.

In general, members are advised that the Fund's supplemental medical coverage for those services, either not included in or limited in the City plan selected, will be covered to the same degree as they are covered for members enrolled in HIP HMO. This coverage will be subject to the same deductibles and subject to the same annual and lifetime limits. The Fund's Catastrophic Stop-Loss Protection will also be provided to these member subject to the same limits as those for members enrolled in HIP-HMO.

Conversion Privilege

Basic City Health Program

Members who terminate employment for reasons other than retirement, or who are on a leave of absence without pay, or are on a leave of absence for reasons of health for longer than a year, can continue their coverage under the provisions of COBRA, described previously, or can convert their health plan coverage to a direct payment basis. Members should contact their payroll secretary or timekeeper or the Department of Education Office of Health and Welfare Services at 65 Court Street, Brooklyn, New York, 11201 or call (718) 935 2828.

Dependents who are no longer eligible for coverage under the City program have the same conversion rights as that which is described above.

Denial of Claims and Claims Review Procedure

In the foregoing pages, 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 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 the five 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. Board of Trustees, employer identification number: 13-6203811. Plan number: 501(c)9. Fiscal year is Oct. 1st to Sept. 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 NY 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 employee. Employees do not contribute. The Fund's assets and reserves are held in custody and invested by the Board of Trustees through various 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.

Guardian Insurance Company underwrites Life Insurance.

Dentcare (Healthplex) underwrites pre paid Dental Programs described in this booklet.

All other benefits are self insured by the CSA 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 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 employee 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, including your employer, your union, or any other person, may fire you or otherwise 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 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 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 Welfare Fund then in effect.

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General Information Concerning the Fund (CONTINUED)

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.

CAUTION

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

Statement of Privacy Practices IN COMPLIANCE WITH HIPAA PRIVACY REGULATIONS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUMAY 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 Welfare Fund

CSA 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.

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Statement of Privacy Practices (CONTINUED)

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 ad-

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Statement of Privacy Practices (CONTINUED)

minister 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. 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.

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Statement of Privacy Practices (CONTINUED)

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 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, pay¬ment 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

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Statement of Privacy Practices (CONTINUED)

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

CSA WELFARE FUND

Your Prescription Drug Coverage and Medicare

Important Notice from CSA Welfare Fund

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CSA Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CSA Welfare Fund has determined that the prescription drug coverage offered by the CSA Welfare Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15th to Dec. 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CSA Welfare Fund coverage will not be affected. However, your prescription drug plan offered by the CSA Welfare Fund is offered to you at no cost as a benefit provided you as a participant in the Fund.

If you do decide to join a Medicare drug plan and drop your current CSA Welfare Fund coverage, be aware that you and your dependents will be able to get this coverage back at the beginning of the next calendar year.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CSA Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CSA Welfare Fund and don't join a Medicare drug plan within 63 continuous days after your current cov-

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Your Prescription Drug Coverage and Medicare (CONTINUED)

erage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: this notice will be published each year in the CSA News. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

For more information please contact:

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

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