Health Benefits Program

CSA
WELFARE
FUND

BENEFIT BOOK ACTIVE MEMBERS JAN.1, 2022 EDITION

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Message From the Chairperson of the Board of Trustees

Dear Colleague:

As you read this CSA Welfare Fund benefit booklet, you will find that your Trustees have developed a comprehensive program designed to fill gaps in your City-provided health plan and provide you with additional benefits to enhance your coverage.

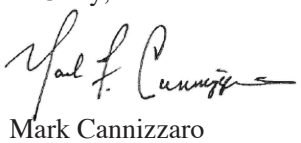
These benefits are provided to you with the monies secured through CSA's collective bargaining agreement with the City of New York and include optical, dental, prescription drugs, hearing aids, life insurance coverage, and benefits coverage for surviving dependents.

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 great pride in the fact that this multi-faceted CSA Welfare Fund benefit program contains such 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.

In Unity,



Mark Cannizzaro
Chairperson
Board of Trustees

CSA WELFARE FUND

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.

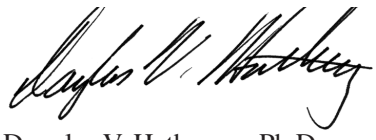
The program developed by the Trustees is unique in that it has been designed to provide members with choices. There is a choice of dental plans, where a member may select a plan which allows access to any dentist or a plan which requires only use of a participating dentist. Optical services are available from 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, with the Fund reimbursing the remainder or reasonable and customary charges.

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 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

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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.

If you enroll yourself for coverage you are eligible to enroll your Dependents for coverage under this Plan. Eligible dependents of covered members are eligible for all CSA Welfare Fund benefits except death benefits. In order for your coverage to be effective for your dependents you must enroll your dependents (following the procedures outlined in the next section). A Dependent may not be enrolled for coverage unless you are also enrolled in this Plan. The following Dependents, as defined by the Fund, are eligible for benefits under the Fund, provided that you properly enroll them:

- Legally married spouse (or Domestic Partner) eligible for and enrolled in the same City-provided health benefits program the Member is enrolled in;
- Dependent children until the end of the month which the child turns 26 years old and include the following
- A natural child of the Member
- A legally adopted child
- A child placed with you for adoption
- A stepchild
- A child supported by the Member or member's spouse or domestic partner who permanently resides in Member's household and for whom the Member is legally responsible
- Any unmarried child, regardless of age, who is incapable of selfsustaining 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 26 and is wholly dependent on the covered employee for support. Applications for such disabled status must be made prior to the age of 26 or at the time of enrollment.

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

Coverage by the Fund for benefits which are supplemental to the City health plan is dependent upon eligibility for coverage under the City plan. No coverage for Supplemental Benefits is provided if a Member and/or Dependent(s) are not enrolled in a City plan. If a member waives City health coverage in favor of a spouse/domestic partner's health plan coverage for supplemental benefits will not exceed those that would be provided has the member not waived City coverage.

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 part-

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ner 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. You must complete and sign the enrollment form and return it to the Fund Office in order for coverage to become effective. For your dependents to be eligible you need to enroll them and provide proof of dependent status as described below. A dependent may not be enrolled for coverage unless the employee is also eligible and enrolled.

• Spouse: Copy of the certified marriage certificate

• Domestic Partner: Documentation showing City coverage for the domestic partner and proof of registration with the Domestic Partnership Registry

• Child: Copy of certified birth certificate showing biological child of employee

• Stepchild: Copy of certified birth certificate, divorce decree between the child's natural parents (if applicable) and marriage certificate between employee and child's natural or adoptive parent.

• Adopted child or child placed for adoption: Court order paper signed by the judge showing employee has adopted or intends to adopt the child and certified birth certificate.

• Child for whom the Member has Legal Guardianship: Court-appointed legal guardianship documents, certified birth certificate and tax documents showing the child is a dependent of the member

• Disabled Dependent Child: Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent relies chiefly on you and/or your spouse for support and maintenance. The plan will require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of dependent child including proof that the child is claimed as a dependent for federal income tax purposes

• Qualified Medical Child Support Order (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice

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 as described below. The Fund reserves the right to request documentation verifying the bona fide relationship of any dependent to the member (e.g. a birth certificate, marriage license, domestic partner registration, etc.)

Special Enrollment

If you did not initially enroll your spouse or dependent children because they had other coverage and they cease to be eligible for that other coverage you may enroll them in the Plan at the time they lose other coverage. In addition, if you acquire a dependent by marriage, birth, adoption or placement for adoption, you may enroll your new dependent effective as of the date of the marriage, birth, adoption or placement for adoption by completing an enrollment card. You must provide he necessary proof (as listed above) in order to enroll your dependent.

You and your dependents may also enroll in this plan if you (or your eligible dependents):

• have coverage through Medicaid or a State Children's health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage, or

• become eligible for a premium assistance program through Medicaid or CHIP

To request enrollment, please contact the Fund Office.

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Effective Date Of Coverage Following Enrollment

If you return your completed enrollment card and all necessary proof to the Fund Office within 31 days of your initial eligibility or the special enrollment event or within 60 days of your loss of Medicaid or CHIP coverage or eligibility for a premium assistance program, coverage will be effective retroactive to the date you were first eligible, the date you add the new dependent or from the date of the loss of other coverage. You may enroll after 31 (or 60) days. However, if you do, coverage will not be effective until the first of the month after the month in which the Fund Office receives your completed material. Keep in mind that no claims for you or your covered dependents will be payable until the Fund Office receives your completed enrollment card as well as the required proof of dependent status. Claims will be denied for any individual not properly enrolled in coverage.

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 are not reimbursed to the Fund in a timely fashion.

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that claim. Failure to provide complete, updated, and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of material facts to the plan.

Coverage for you and/or your dependents may be terminated retroactively (rescinded):

- In cases of fraud or intentional misrepresentation (in such cases you will be provided with 30-day notice);
- Due to non-payment of premiums (including COBRA premiums). Failure to notify the Plan of a loss of dependent status for any dependents (including divorce or legal separation or a child aging out of the Plan) constitutes a failure to pay COBRA premiums. In these situations, coverage may and will be terminated retroactively to the date of the event (without advanced notice).

If coverage is terminated, you may be required to repay to the Plan amounts incorrectly paid by the Plan. The Trustees may commence legal action against a member or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Trustees may also offset future claim payments with respect to the Member or dependent to recover amounts owed.

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Eligibility for CSA Welfare Benefits

When You Are Covered

You will be eligible for 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 fulltime work for any reason other than authorized vacation or because of illness or injury, on the date you would otherwise become covered for benefits the effective date of your coverage will be deferred until the date on which you return to active fulltime work.

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. 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 on which the Dependent fails to meet the criteria as a dependent under the plan, as follows:
  - — For Spouse, the date of divorce or legal separation
  - — For Domestic Partner, the date of the dissolution of the domestic partnership or ineligibility for coverage under the member's health plan
  - — For Child, the end of the month in which the Child reaches his/her 26th birthday
- 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

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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. 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.

Qualified Medical Child Support Orders (QMCSOs): If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a Qualified Medical Child support Order (QMCSO). A WMCSO is a judgement, decree, or order issued by a state court or agency that creates or recognizes the existence of an eligible child's right to receive health care coverage. The order must comply with applicable law and must be approved and accepted as a QMCSO by the Fund in accordance with Plan procedures. A copy of the Plan's QMCSO qualification procedures and a sample is available free of charge at the Fund Office.

Your Right to Continuation of Coverage (COBRA)

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by the Federal Government. 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. However, the information in this booklet only pertains to the coverage you have through the CSA Welfare Fund which includes Dental, Optical, Prescription Drug benefits, laser eye surgery benefits and supplemental medical benefits. Information on your City health plan coverage should be provided to you by the City and Department of Education. In addition, you will have to make separate elections in order to continue your coverage under each plan.

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

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee/member, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: your hours of employment are reduced, or your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee/member, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: your spouse's hours of employment are reduced or employment ends for any reason other than his or her gross misconduct; your spouse dies or becomes entitled to Medicare benefits (under Part A, Part B, or both); or you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events: the parent-employee dies or becomes entitled to Medicare benefits (Part A, Part B, or both); the parent-employee's hours of employment are reduced or employment ends for any reason other than his or her gross misconduct; the parents become divorced or legally separated (for step-children only because step-children will lose coverage in the event of a divorce); or the child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Fund has been notified that a Qualifying Event has occurred. The City is responsible for notifying the Fund Office of termination of employment, reduction in hours, death of the member. However, you or your family should also notify the Fund Office promptly if any such Qualifying Event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notice.

For all other Qualifying Events (your divorce or legal separation from your spouse, or your dependent child losing eligibility for coverage as an eligible dependent), you and/or a family member must inform the Plan in writing of that event no later than sixty (60) days after that Qualifying Event occurs.

The written notice should be sent to the Fund Office. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents. If such notice is not received by the Fund Office within the sixty (60)

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day period, the Qualified Beneficiary(ies) will not be entitled to choose COBRA Continuation Coverage.

When the Fund is notified that a Qualifying Event has occurred, the Fund will then provide you and/or your eligible dependents with notice of the date on which your coverage will end, and the information and election form that you will need in order to elect COBRA coverage. Under the law, you and/or your eligible dependents will then have only 60 days from the later of the date you ordinarily would have lost coverage because of one of the Qualifying Events described above, or the date you and/or your eligible dependents received the notice, to apply for COBRA coverage.

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN 60 DAYS AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Each Qualified Beneficiary has an independent (separate) right to elect COBRA coverage. COBRA coverage may be elected for some members of the family and not others. In addition, one or more Eligible Dependents may elect COBRA even if the member does not elect it. However, in order to elect COBRA coverage, the family members must have been covered by the Plan on the date of the Qualifying Event or became an eligible dependent by birth, adoption, or placement for adoption during the period of COBRA coverage. A member may elect COBRA coverage on behalf of his or her spouse and a parent may elect or reject COBRA coverage on behalf of a child living with him or her.

You are responsible for the entire cost of COBRA coverage and can pay for the coverage on a monthly basis. When you and/or your eligible dependents become entitled to this coverage, the Fund will notify you of the COBRA premium amounts that you must pay. Covered persons who continue full coverage under COBRA pay 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Coverage for Disabled Eligible Participants").

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Fund not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. Payments for subsequent months are due on the first day of the month for which coverage is provided. You will NOT be sent any bills or reminders for subsequent months. It is your responsibility to make payment by the first of the month. If you do not remit your payment by the due date or within the grace period for that payment, your COBRA coverage will end.

Although payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.

In the event the Plan is notified of a Qualifying Event but the Fund Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why the COBRA coverage is not available. This notice of the unavailability of the COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

COBRA Coverage for Disabled Eligible Participants

If, during an 18-month COBRA coverage period the Social Security Administration determines that you (or a member of your family who is eligible for COBRA coverage) were disabled at some time before the 60th day of COBRA coverage, the disabled person and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of COBRA coverage, for a total maximum of 29 months. You must notify the Fund of the determination of your disability in writing within 60 days of the date of that determination and before the end of the 18-month period of COBRA coverage. The notice of disability must be in writing. If the 18-month period of COBRA Coverage is extended because of Social Security disability, the COBRA premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month, 30 days after Social Security has determined that you and/or your Eligible Dependent(s) are no longer disabled;
- The end of the 29 months COBRA coverage;
- The date the disabled person becomes entitled to Medicare.

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You must notify the Fund Office in writing within 30 days of a final Social Security determination that you are no longer disabled.

Multiple Qualifying Events While Covered Under COBRA

If, during an 18-month period of COBRA coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A or B or both), or if an dependent child ceases to be an eligible dependent under the Plan, the maximum COBRA continuation period for the affected spouse and/or child(ren) is extended to 36 months from the date of your termination of employment or reduction in hours. In no case are you (the member) entitled to COBRA coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA coverage may not be extended beyond 18 months from the loss of coverage due to the initial Qualifying Event.

In no event is anyone else entitled to COBRA coverage for more than a total of 36 months.

Early Termination of COBRA Coverage

COBRA coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

• The first date of the time period for which you do not pay the COBRA premiums within the required timeframe after electing COBRA

• The date, after the date of the COBRA election, in which you or your eligible dependent(s) first become covered by another group health Plan

• The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65)** Under federal COBRA rules, your COBRA coverage may be terminated when you become entitled to Medicare. 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.

• The date the Plan terminates its group health plan and no longer provides group health insurance coverage to its members

• The date the Employer that employed you prior to the Qualifying Event has stopped contributing to the Plan; and (1) the Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered under this Plan; or (2) the Employer starts contributing to another multiemployer plan that is a group health plan

• If coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled, the date you are no longer disabled

The Fund will notify the Qualified Beneficiary(ies) if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the Qualified Beneficiary(ies) to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary(ies) may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund determines that COBRA coverage will terminate early.

Other Coverage Options

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

Questions or To Give Notice of Changes in Circumstances

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans maintained by a state or local government employer, you can contact CMS at https://www.cms.gov/CCIIO/programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html. For more information about the Marketplace, visit www.HealthCare.gov.

Keep The Plan Info

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

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

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

Rules for determining primary and secondary benefits are:

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. The plan that covers a person either as an active employee (that is an employee who is neither laid off nor retired) or that active employee's dependents, pays first and the Plan covers the same persona s a laid-off or retired employee's dependent, pays second. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of payment, this rule is ignored
4. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. If a person is covered other than as a dependent (that is as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law one plan and as a dependent of an active employee under another plan, the order of the benefits is determined by Rule 1 rather than by this rule.
5. If none of the four previous rules determine the order of benefits, the plan that covered the person for the longer period of time pays first and the plan that covered the person for the shorter period of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered by the plan presently in force.

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 NY State or another jurisdiction's No Fault Insurance Law.

CSA WELFARE FUND

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 is the primary payer for any employee or dependent who is Medicare eligible based upon age or disability. OBRA, effective January 1, 1987, requires that coverage under the City's health program be primary coverage for any employee or dependent who is Medicare eligible and covered under the active plan and Medicare coverage will be secondary. Medicare-eligible individuals may elect to have Medicare their primary (and only) coverage under the provisions of TEFRA, DEFRA, COBRA, or OBRA but if they do, they waive their right to coverage under the City's health program.

NOTE: There is one exception: End Stage Renal Disease (ESRD): if you are actively employed and you or any of your dependents become entitled to Medicare because of end stage renal disease (ESRD), this Plan pays first and Medicare pays second during the coordination period for 30 months starting the earlier of:

- The month which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant

Then, if you are still considered actively employed, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

When this Plan is secondary to Medicare, this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. To the extend allowed under the law, benefits that are paid by this Plan when it is secondary to Medicare are reduced by the amounts payable under Medicare Parts A(Hospital) and Part B(Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Parts A and B. Therefore, you should consider enrolling in Medicare Parts A and B when this Plan is secondary to Medicare in order to receive the maximum benefits payable under this Plan.

If you are an active employee age 65 or older, you have the right to reject the coverage and use Medicare as your primary carrier. 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 and that Medicare does not cover such as dental, life insurance, optical and hearing aid benefits. You will not be eligible for prescription drug, supplemental coverage, or stop-loss coverage.

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 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. The Fund uses the 85th percentile of the Fair health benchmark for the geographic area where the service is provided:
- 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.

NOTE: This is not a complete benefit description or contract and should only be viewed as a summary to assist you in understanding your Life Insurance benefit. The complete terms of the benefit are described in the individual certificate of insurance. The terms, conditions, and exclusions are outlined in the Certificate of Insurance. Please contact the Fund to obtain the Certificate of Insurance.

Hearing Aid Benefits

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

Benefits

A reimbursement of up to $800 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.

CSA WELFARE FUND

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 PrePaid 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. Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA because they are administered under a separate contract.

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.

CSA WELFARE FUND

Optical Benefits

All members and their eligible dependents are covered for optical benefits. The benefit, a maximum reimbursement of $100, is provided once every 12 calendar months. Optical benefits are treated as a standalone (or excepted) benefit under HIPAA and PPACA because they are administered under a separate contract.

EXAMINATIONS ARE ONLY COVERED AS PART OF A CONTACT LENS PACKAGE.

Reimbursement is as follows:

Single vision lenses and frame	$100
Bifocal and multi focal lenses and frame	$100
Single vision lenses only	$45
Bifocal or multi focal lenses only	$45
Frame only	$35
Contact lenses including all services	$100

How to Obtain Benefits

Write, call the Fund office, submit a request by emailing voucherrequest@csawf.org, or complete the voucher request form on the Fund's website, www.csawf.org. You must specify for whom the certificate is intended. Certificates are not transferable and must be returned to the Fund if not used.

Vouchers 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.

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.

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.

CSA WELFARE FUND

Hearing Aid Benefits

All members and their eligible dependents are covered for hearing aid benefits. A reimbursement of up to $800 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.

Please visit the fund's website, www.csawf.org and click on the Benefit Providers link on the left to find 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, otherwise reimbursement will be made to the member.

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.

Prescription Drug Benefits

All members and eligible dependents are covered for prescription drugs through the CSA Welfare Fund Prescription Drug Plan administered by OptumRx.

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.

OPTUMRx 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 OPTUMRx Pharmacy in your geographic area.

There is an annual $50.00 per person / $150.00 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.

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Chronic or Maintenance Drug Plan

You must utilize our mail order drug plan, Optum home delivery, 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 copayment 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.

The plan has an Out-of-Pocket Limit for In-Network Prescription Drug benefits which limits your annual cost sharing for covered essential health benefits received from In-Network pharmacies related to plan deductibles, coinsurance, and copayments to the amounts permitted under the Affordable Care Act and implementing regulations. The Out-of-Pocket limit is the most you will pay during the calendar year before the plan starts to pay 100% for covered essential health benefits received from in-network providers. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount published by the Department of Health and Human Services. The Out-of-Pocket Limit is currently $8,550 for an individual and $17,100 for a family.

Medications That Require Prior Authorization

Some medications must be authorized for coverage because they're only approved or effective in treating specific illnesses, they cost more or they may be prescribed for conditions for which safety and effectiveness have not been well-established. If you must start taking a medication that requires prior authorization right away, two options may be available to you. First, ask your doctor if a sample is available. If not, check with your pharmacy to request a short-term supply of five days or less — keep in mind you will be responsible for the full cost at that time. If the prior authorization request is approved, then your pharmacist can dispense the rest of your prescription.

You, your pharmacist or your doctor can start the prior authorization review process by contacting Optum's Prior Authorization Department. A pharmacy technician then works with your doctor to get the information needed for the review. Once they receive a completed prior authorization form from your doctor, Optum conducts a clinical review within two business days. They then send you and your doctor a letter regarding the prior authorization decision. Since drugs are deleted and added to the list frequently, see the Medications that require Prior authorization for the most up-to-date list of drugs which require prior authorization.

Formulary

The Formulary outlines the most commonly prescribed medications from your plan's complete pharmacy benefit coverage list, also known as a Prescription Drug List (PDL). A formulary identifies the drugs available for certain conditions and organizes them into cost levels, also known as tiers. An important part of the Formulary is giving you choices so you and your doctor can choose the best course of treatment for you. The Formulary may change. you are encouraged to visit Optum's website, which is listed on your prescription ID card, for the current formulary. This website is the best source for up-to-date information about all of the medications your pharmacy benefit covers, possible lower-cost options and cost comparisons. You can also find a listing of the formulary drugs on the Fund's website, www.csawf.org.

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 nonparticipating pharmacy, you may submit your itemized bill to OptumRx 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.

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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. Injectable 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.

Preventive Care

Required by the Patient Protection and Affordable Care Act

If you are a participant in the City of New York EmblemHealth/GHI Comprehensive Benefit Program (GHI-CBP), or HIP HMO Health Plan Preventive Medications required by the Affordable Care Act are obtained through the health plan. The CSA Welfare Fund provides these benefits for those in plans other than the GHI-CBP Health Plan and HIP-HMO Health Plan.

Preventive Prescription Drug Benefit

This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided on an in-network basis only, with no cost-sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Prescription Drugs described in the United States Preventive Services Task Force (USPSTF) A and B recommendations
- Prescription Drugs described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC)
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women for Prescription Drug coverage.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible. If preventive services are received from a non-network provider, they will not be eligible for coverage under this Preventive Services benefit unless there is no provider in the Plan's network who can provide the particular service.

In some cases, federal guidelines are unclear about which pre-

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Preventative Care (continued)

ventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Benefit Overview

Prescription Drug Preventive Services Covered with No Cost-Sharing: The following benefits are available under the Fund's Prescription Drug benefit with no cost-sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

Non-preventive Services are not covered without Cost-Sharing: The plan will impose cost-sharing for treatment that is not a recommended preventive Prescription Drugs.

Preventive Services for Dependents: All covered participants and dependents are eligible to obtain, without cost sharing, all required in-network preventive Prescription Drugs applicable to them (e.g., for their age group) where an attending provider determines that the services are age and developmentally appropriate.

Covered Preventive Prescription Drugs for Adults

a. Low-dose Aspirin to prevent cardiovascular and colorectal cancer disease, when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin for at least 10 years. A prescription must be submitted in accordance with plan rules.

b. Cessation interventions for tobacco users including all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

c. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.

d. Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

Covered Preventive Prescription Drugs for Women, Including Pregnant Women

a. Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia.

b. Risk-reducing medications for breast cancer (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.

c. FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, including barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

d. Folic Acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.

e. Cessation interventions for tobacco users including all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Covered Preventive Services for Children

a. Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.

b. Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices.

Immunizations

• Immunizations are covered by the City-provided basic health plan. These are NOT covered by the CSA Welfare Fund

Preventive Services Coverage Limitations and Exclusions

1. Prescription Drugs covered under the Preventive Services benefit are not also payable under other portions of the Plan.

2. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Prescriptions which must be sat-

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Preventative Care (continued)

isfied in order to obtain payment under the Preventive benefit.

3. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus are not covered.

4. Benefits are not covered when they are provided for the following purposes:

a. When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

b. When related to judicial or administrative proceedings;

c. When related to medical research or trials; or

d. When required to maintain employment or a license of any kind.

5. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

6. Prescription drugs related to a man's reproductive capacity, such as condoms.

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.

Your City Provided Benefits

Through collective bargaining agreements, the City of NY and the CSA have cooperated in the design of the City Employee Health Benefits Program. The benefits provided are designed to provide you with the fullest possible protection that can be purchased with the available funding.

The City of NY Office of Labor Relations, Employee Health Benefits Program, 22 Cortlandt St, 12th floor, NY, NY 10007, has published a booklet describing your coverage. The various insurance carriers involved in the benefit program have also published booklets detailing the coverage provided by them. These booklets are available to you at your work location or through the Department of Education Office of Health & Welfare Services, HR Connect office, 65 Court Street, Room 101, Brooklyn, NY 11201.

The following serves only as a brief description of your City provided benefit program, the details of which can be found in the publications mentioned earlier.

GENERAL DESCRIPTION OF PROGRAM: The City of NY currently offers you a choice of several different health insurance plans. A detailed description of the specific benefits provided under each of these programs can be found in "The NYC Employee Benefits Program, Summary Program Description" booklet available from your payroll secretary and is also available from the insurance carrier.

ENROLLMENT / Cost to Enrollees: Basic medical and hospital coverage is provided either as a paid in full benefit by the City of New York for some plans or may require an additional charge to the employee through payroll deduction.

Optional Benefits Riders: Each health plan also offers an optional benefits rider consisting of various benefits which are not part of the basic plan. You may elect the optional benefits rider coverage when you enroll. The cost of optional riders is paid for by the member through payroll deductions. CSA Welfare Fund members who are enrolled in GHI/CBP Empire Blue Cross Blue Shield or HIP/HMO will find that their cost for the additional benefits under the optional rider is substantially reduced. Since the Fund provides such benefits as prescription drugs that cost is excluded from the rider cost. Contact the Fund if you are in doubt as to the selection of a rider.

Deductions from Paychecks: If you apply for an Optional Benefits Rider or enroll in certain HMO's which include an additional cost for the basic plan, your paycheck should show a deduction for this cost. If your check does not reflect the deduction within two months after submitting an application form, you must notify your personnel or payroll office.

Health Benefits Buy-Out Waiver Program

The City offers a financial incentive to employees who waive their his 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.

CSA WELFARE FUND

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.

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 per person 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. Chiropractic care is included in all City health plans. Members obtain these services solely through the City health plan in which they are enrolled.

5. Private Duty Nursing: 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.

6. Appliances: 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 readymade shoes, heating pads or exercise equipment, are not considered covered expenses

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

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.

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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 outofpocket 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 outofpocket costs are all deductibles and coinsurance charges applied by GHI or Blue Cross (not the copayment 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.

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.

Filing of Claims

All claims for coverage provided by a city health plan should be filed in accordance with the applicable rules as laid out in the City Benefit Book.

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.

Catastrophic Stop-Loss Coverage

Should a member or eligible dependent incur outof--pocket expenses for covered services not provided or fully reimbursed by HIPHMO 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 HIPHMO, 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 HIPHMO.

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 HIPHMO. 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.

Enrollment in Basic City Health Program

You and your eligible dependents are only eligible for benefits under this Plan if you are enrolled in a New York City health benefits plan. The plan will not reimburse you for any expenses if such expenses are reimbursable or have been reimbursed by any other health insurance plan, provider, or entity. If only a portion of an expense has been reimbursed (e.g. because another plan paid part of such expense) specifically listed as covered medical expenses. No other expenses are covered even if they are considered medical care. In no event are any premiums for individual health insurance a permissible plan benefit, whether purchased in the individual or health insurance marketplace, nor will this Plan coordinate with such insurance coverage. You will not be able to receive reimbursement under this plan after your coverage terminates except as required under COBRA. In addition, you may permanently opt-out of the benefit and waive future reimbursement from the Plan once per year by contacting the Fund Office and completing an opt-out form.

Denial of Claims and Claims Review Procedure

Internal Claims and Appeal Procedures

This section describes the procedures followed by the CSA Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for Hearing Aid, Dental, Optical, Laser Eye Surgery, Prescription Drugs, Supplemental and Catastrophic Stop-Loss Coverage, and Life Insurance Benefits.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

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General Information

Claims Administrator(s): The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator and Types of Claims Processed	*How to File Claims*
Self-Administered Welfare Fund Benefits Post Service Claims for Laser Eye Surgery, Optical and Hearing Aid CSA Welfare Fund 40 Rector Street, 12th Floor New York, NY 10006-6061	Write, call the Fund office, or submit a request by emailing voucherrequest@csawf.org through the Fund's website requesting a claim form. 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.
Prescription Drug Program Pre-Service Drugs and Post-Service Claims for Out–of-Network Retail Drugs OptumRx P.O. Box 407096 Fort Lauderdale, FL 33340-7096 800-645-3332 www.optum.com	Write, call the Fund office, or submit a request by emailing voucherrequest@csawf.org through the Fund's website requesting a claim form. 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.
Dental Programs Post-Service Dental Claims Indemnity Plan administered by S.I.D.S. Self Insured Dental Services 303 Merrick Road, 3rd Floor Lynbrook NY 11563 Dentcare Pre-Paid Dental Program administered by Healthplex DMO Healthplex, Inc. PO Box 211672 Eagan MN 55121 www.optum.com	See the Dental Benefits section for details on how to file an Out-of-Network claim.

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

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CSA WELFARE FUND

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

• A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;

• A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

• A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims: Health benefit claims can be filed for Hearing Aid, Dental, Optical, Laser Eye Surgery, Prescription Drugs, Supplemental Coverage and Catastrophic Stop-Loss Coverage benefits.

There are four categories of health claims as described below:

• Pre-Service Claims (applicable to prescription drug benefits) - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained.

• Concurrent Claims (applicable to prescription drug benefits) - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

• Post-Service Claims (applicable to Hearing Aid, Dental, Optical, Laser Eye Surgery, Prescription Drugs, Supplemental Coverage and Catastrophic Stop-Loss Coverage) - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Life Insurance Claims

A Life Insurance Claim is a request by a designated beneficiary for benefit payment following the death of the participant.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

• Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);

• Be received by the Plan Administrator or Claims Administrator (as applicable);

• Name a specific individual participant and his/her Social Security Number;

• Name a specific claimant and his/her date of birth;

• Name a specific medical condition or symptom;

• Provide a description and date of a specific treatment, service or product for which approval or payment is request-

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Claim Elements (continued)

ed (must include an itemized detail of charges);

• Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and

• When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is not a claim if it is:

• Not made in accordance with the Plan's benefit claims filing procedures described in this section;

• Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;

• Made by a person who will not identify himself or herself (anonymous);

• A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;

• A request for prior approval where prior approval is not required by the Plan;

• An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

• The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline: Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

CSA WELFARE FUND

Health Care Claims – Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Pre-Service Claims - applicable to prescription drug benefits

Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Urgent Care Claims – applicable to prescription drug benefits

In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, the Claims Administrator will notify you as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

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Health Care Claims (continued)

Post-Service Claims - applicable to Hearing Aid, Dental, Optical, Laser Eye Surgery, Prescription Drugs, Supplemental Coverage and Catastrophic Stop-Loss Coverage claims

Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Concurrent Claims - applicable to prescription drug benefits

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

Life Insurance – Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination: If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

• Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);

• Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review);

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Initial Determinations of Benefit Claims (continued)

• If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.

• Reference the specific Plan provision(s) on which the denial is based;

• Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

• Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;

• If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;

• If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

• Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims: If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you within the applicable timeframe after the Claims Administrator's receipt of the claim.

INTERNAL APPEAL REQUEST DEADLINE

Health Care Claims (applicable to Hearing Aid, Dental, Optical, Laser Eye Surgery, Prescription Drugs, Supplemental Coverage and Catastrophic Stop-Loss Coverage): If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

Life Insurance Benefits: If an initial life insurance claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period.

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

CSA Welfare Fund Board of Trustees
40 Rector St, 12th floor
New York, NY 10006
(212) 962-6061
www.csawf.org

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

• The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

• The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

• A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

• The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit

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Appeal Procedures (continued)

determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

• A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

• In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

o Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

o Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

o The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

Health Care Claims

• Pre-Service Claims (applicable to prescription drug benefits). A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

• Concurrent Claims (applicable to prescription drug benefits). You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Fund Administrator. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

• Post-Service Claims (applicable to Hearing Aid, Dental, Optical, Laser Eye Surgery, Prescription Drugs, Supplemental Coverage and Catastrophic Stop-Loss Coverage). A written (or electronic, as applicable) notice regarding the Plan's determination on the internal appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

Life Insurance Claims

A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

• The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision

• Reference the specific Plan provision(s) on which the denial is based

• A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

• A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal

• If the denial was based on an internal rule, guideline, protocol or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request

• If the denial was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request

This concludes the appeal process under this Plan. The Plan does not offer a voluntary appeal process.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a claimant) along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Administrator).

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (e.g. notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the your legal spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative for one (1) year before requiring a new authorization/until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Limitation On When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. In addition, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided.

Elimination Of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility of Payment

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

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 daytoday 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 – 40 Rector Street, 12th floor, New York NY 10006 Board of Trustees, employer identification number: 136203811 Plan number: 501C9. Fiscal year is October 1st to September 30th.

The Fund was established as a result of Collective Bargaining between the Council of School Supervisors and Administrators of the City of New York, Local 1, AFSA, AFLCIO and the Department of Education of the City of New York located at 65 Court Street, Brooklyn, New York 11201. Contributions are predicated on the amount stipulated in the Collective Bargaining Agreements.

Contributions are provided at annual rates, prorated monthly on behalf of each covered 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 prepaid Dental Programs described in this booklet.

All other benefits are selfinsured 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.

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 Trust-

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General Information Concerning the Fund (CONTINUED)

ees, 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

Your Rights

When it comes to your health information, you have certain rights. This explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records:	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We'll consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

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CSA WELFARE FUND

Statement of Privacy Practices

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission

- Marketing purposes
- Sale of your information

Other Uses And Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	*Example: We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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CSA WELFARE FUND

Statement of Privacy Practices

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Jan. 1, 2015. This Notice of Privacy Practices applies to the following organizations: CSA Welfare Fund.

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 October 15th to December 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.

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*.

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Your Prescription Drug Coverage and Medicare (CONTINUED)

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
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