

**BRONXVILLE PUBLIC SCHOOL
EMPLOYEES' BENEFIT TRUST BENEFIT
BOOKLET**

DENTAL

VISION

LEGAL SERVICES

LIFE INSURANCE

Revised April, 2016

**BRONXVILLE PUBLIC SCHOOL
EMPLOYEES' BENEFIT TRUST
TABLE OF CONTENTS**

INTRODUCTION	1
ELIGIBILITY	1
LEAVE OF ABSENCE	1
RETIREE PARTICIPATION	2
EXTENDED BENEFITS PROVISION	2
COBRA – CONTINUATION OF COVERAGE	2
FAMILY & MEDICAL LEAVE ACT (FMLA)	4
APPEALS	5
DENTAL PLAN	5-10
ELIGIBILITY	5
HOW TO FILE A CLAIM.....	5
PRE-TREATMENT OF ESTIMATES.....	6
COMMON CLAIM PROBLEMS	6
COORDINATION OF BENEFITS	6-7
DESCRIPTION OF DENTAL BENEFITS.....	7
BENEFIT DETERMINATION	7
LIMITATIONS & EXCLUSIONS.....	8
COVERED DENTAL SERVICES.....	8
DEFINITIONS.....	10
VISION PLAN.....	10
GROUP LEGAL SERVICES	11
SELF-INSURED DISABILITY PLAN.....	13
LIFE AND AD&D INSURANCE.....	13
GENERAL INFORMATION	14
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES.....	15-18
ADDENDUM A – SCHEDULE OF BENEFITS SUPPLEMENT	19

INTRODUCTION

The Bronxville Public School Employees' Benefit Trust (BPSEBT) was created in September, 1983 on behalf of the employees of the Board of Education of the Bronxville Union Free School District to receive and administer funds for the purchasing of benefits for these employees.

The Trust is administered by a seven member Board of Trustees appointed pursuant to the terms of the Trust Document. Each Trustee serves a three-year term of office.

ELIGIBILITY

A. PARTICIPANT

1. Any Employee who is eligible for benefits according to the provisions of the Rules of Eligibility of the Bronxville Public School Employees' Benefit Trust.
2. The eligible Employee's lawful spouse
3. The eligible Employee's dependents:
 - a. Unmarried child who has attained the age of two weeks but has not attained the age of nineteen years and is not a full time student at an accredited institution.
 - b. Unmarried child who is a full-time student at an accredited institution of learning and has attained the age of nineteen years but has not attained the age of twenty-five years. Full-time student is defined as carrying at least twelve credits. Proof is required. Termination of coverage for a post-secondary student not returning to school is thirty days from the last day of enrollment. (See also COBRA.)
 - c. Unmarried child who was handicapped before the limiting age (19 or 25 if full-time student) and is dependent upon parents or legal guardian for support. The Plan may require written proof of such dependency. Eligibility ends when the parent-employee retires or otherwise ends employment.
4. A Domestic Partner with proper proof as required by the Fund.
5. The eligible Retiree as defined in this plan.
6. The eligible Retiree's lawful spouse or domestic partner.

B. MEMBERSHIP

All full-time and part-time administrators, teachers, clerical, custodial, and professional civil service employees are eligible to participate in the Benefit Trust Fund according to the eligibility rules established by the Board of Trustees and reflecting any agreements between said employees and the Board of Education.

A part time employee is defined as one for whom the Board of Education pays at least 50% of their health insurance premiums. The Board of Education will pay the same percentage for coverage administered by the Trust as it does for health insurance and the employee must pay the remainder of the premiums. Teacher Aides are eligible provided they pay the full premium to the Trust Administrator.

Each year the Board of Trustees will declare an "Open Enrollment" period at which time employees may elect the coverages they wish to receive for the following fiscal year. (The fiscal year runs July 1 - June 30.) Enrollment in the various programs is available only during this period. No changes can be made during the course of the year except in the case of significant changes in an employee's life situation; for example: birth, death of a spouse, and change in dependent status, etc. Notification of such change must be made to the Trust Administrator in writing before any change in coverage can be processed.

LEAVE OF ABSENCE

Any member of the Trust granted an unpaid leave of absence by the Board of Education after at least one year of continuous membership in the Trust may maintain membership through direct personal payment to the Trust. Payment will be 100% of the yearly charge as determined by the Trustees. Payment in full will be due and payable fifteen (15) days after the leave begins. If the leave commences during a fiscal year, the amount will be pro-rated. An unpaid leave of absence effective at the end of the school year means coverage terminates June 30th. If membership is not maintained, the person on leave will not be covered for any benefits. Upon returning to active employment or paid leave status, membership will be resumed at the same level of benefits, which the member had prior to the leave of absence.

RETIREE PARTICIPATION

Beginning July 1, 1988, Trust members who retire are eligible to continue certain coverages, must elect those coverages at the time of retirement and may not increase them after the effective date of retirement. The following definition identifies those eligible: "Retiree" shall mean any full-time employee who retires from the Bronxville Public Schools under the eligibility rules established by the New York State Teachers Retirement System (for teachers and administrators) and who has been a member of the BPSEBT for at least five (5) consecutive years just prior to retirement, or who meets the retirement eligibility rules established by the Bronxville Board of Education (for clerical, custodial, and civil service employees) and who has been a member of the BPSEBT for at least five (5) consecutive years just prior to retirement.. The following coverages are available to retirees:

A. DENTAL (same yearly benefits as for active employees)

1. Individual
2. Family (individual and spouse only - must have carried this for at least five consecutive years just prior to retirement)

B. VISION (same yearly benefits as for active employees)

1. Individual
2. Family (individual and spouse only - must have carried this at least five consecutive years just prior to retirement)

C. LIFE

1. Individual (half of basic coverage available as active employee; coverage is reduced to \$2000 upon reaching the age of 70)

D. LEGAL

Premiums for individual and individual/spouse policies will be determined annually by the Trustees. If a retiree terminates any coverage, the coverage may not be reinstated.

EXTENDED BENEFITS PROVISION

If a Participant's eligibility for coverage under this Plan terminates for any reason, benefits are available for up to thirty (30) days following termination of eligibility but only to cover those services received before the termination date. All charges filed for will be applied to the fiscal year maximum of the year termination took place. (See also COBRA).

COBRA - CONTINUATION OF COVERAGE

On April 7, 1986, a Federal law was enacted-Public Law 99-272, Title X - requiring that most employers sponsoring group dental/vision plans offer employees and their families the opportunity for a temporary extension of coverage - called continuation coverage - at group rates in certain instances where coverage under the plan would otherwise end.

Members have a right to choose this continuation coverage (for a maximum of 18 months) on the loss of dental/vision coverage because of a reduction in hours of employment or the termination of employment, except for reasons of gross misconduct.

The spouse of an employee covered by this dental/vision plan has the right to choose continuation coverage (for a maximum of 36 months) if coverage is lost under this plan for any of the following reasons:

- (1) the death of your spouse;
- (2) divorce or legal separation from spouse; or
- (3) spouse becomes eligible for Medicare.

COBRA (CONT'D)

As a dependent child of an employee covered by this plan, he or she has the right to continuation coverage (for a maximum of 36 months) if the coverage is lost for any of the following reasons:

- (1) the death of the parent/employee;
- (2) parent's divorce or legal separation;
- (3) a parent becomes eligible for Medicare; or
- (4) the dependent child ceases to be an eligible dependent.

In the event of a Bankruptcy, certain retirees and their dependents also have rights of continuation. Under the law, the employee or a family member has 60 days to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the plan.

Your employer has the responsibility to notify the plan administrator in the case of an employee's death, termination of employment or reduction in hours, or Medicare eligibility.

When the Bronxville Public School Employees' Benefit Trust is notified that one of these events has happened, you will be notified that you have the right to choose continuation coverage.

Under the law, you have no more than 60 days from the day you would lose coverage because of one of the events described above to inform your employer or the plan administrator (whichever is appropriate) that you want continuation coverage. Once you notify the employer that you elect COBRA, you have 45 days to pay for COBRA.

If you do not choose continuation coverage, your dental/vision benefits will end.

If you choose continuation coverage, your employer is required to offer you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

- (1) your former employer no longer provides dental/vision coverage to any of its employees;
- (2) the premium for your continuation coverage is not paid;
- (3) you become eligible for Medicare;
- (4) you have reached the end of the 18, 29 or 36 month period;
- (5) the date you become eligible for benefits under another group plan provided the plan does not exclude preexisting conditions from coverage;
- (6) the date a former spouse or dependent child becomes eligible for coverage under another group dental/vision program;

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium plus 2% administration fee for your continuation coverage. The law also states that, at the end of the 18th month, 29th month or 36th month continuation coverage period, your coverage will be terminated.

Continuance During Disability

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment (or, effective January 1, 1997, during the 60 day period thereafter). To benefit from this extension, you must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual also must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Any questions about this law should be addressed to your Plan Administrator. Also, if you have changed marital status, or you or your spouse have changed addresses; please notify your Plan Administrator.

FAMILY AND MEDICAL LEAVE ACT (FMLA)
as Federally Mandated

Family and Medical Leave

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) your coverage may be continued on the same basis as if you were an actively-at-work employee for up to 12 weeks during the 12 month period, as defined by your employer, for any of the following reasons:

- (a) to care for your child after the birth or placement of a child with you for adoption or foster care, as long as such leave is completed within 12 months after the birth or placement of the child;
- (b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
- (c) for your own serious health condition.

In the event you and your spouse are both covered as employees of the School District, the continued coverage allowed under item (a) and (b) may not exceed a combined total of 12 weeks.

Conditions:

- (a) If, on the day your coverage is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Coverage for you and any eligible dependents will begin in accordance with the terms of the policy. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
- (b) You are eligible to continue coverage under FMLA if:
 - (1) you have worked for your employer for at least one year;
 - (2) you have worked at least 1,250 hours over the previous 12 months;
 - (3) your employer employs at least 50 employees within 75 miles from your worksite; and
 - (4) you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.
- (c) In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the policy during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the policy. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
- (d) You and your dependents are subject to all conditions and limitations of the policy during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
- (e) If requested by us, you or your employer must submit proof acceptable to Claims Administrator that your leave is in accordance with FMLA.
- (f) This FMLA condition is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the policy following the day your FMLA continuation ends.
- (g) FMLA continuation ends on the earliest of:
 - (1) the day your return to work;
 - (2) the day you notify your employer that you are not returning to work;
 - (3) the day your coverage would otherwise end under the policy;
 - (4) the day your coverage has been continued for 12 weeks.

Important Notice:

Contact your Benefits Coordinator in the school district office for additional information regarding FMLA.

APPEALS

In the event a part or all of a claim is denied due to the enforcement of the Plan document, you may appeal to the Plan Administrator. All appeals must be in writing and directed to our plan administrator. Please provide all information needed to support your appeal. The letter should be sent to our administrator so that it can be presented at the next scheduled meeting of the Trustees. Appeals must be received no later than 60 days after you receive the determination in question.

If a settlement agreeable to both the Trustees and the claimant cannot be reached, the matter will be submitted to arbitration in Westchester County under the existing rules of the American Arbitration Association. Both parties share the cost of arbitration equally.

PARTICIPATION IN THE DENTAL PLAN

TYPES OF COVERAGE

Two types of coverage are available:

1. Individual - provided at no cost to the employee through contractual agreement with the Board of Education.
2. Family - includes the individual employee and his/her eligible dependents. A yearly premium is charged to the employee as determined by the Trustees.

ELIGIBILITY

An employee/dependent becomes eligible to receive benefits under the Dental Plan upon completing the eligibility rules outlined previously.

In addition, the eligibility rule regarding new members is in effect for the dependents. (The individual employee will be an on-going participant and, therefore, not affected by the new subscriber rule.) *If family coverage is dropped and then reinstated at a later date, there is a waiting period of 24 months for dependent coverage.* This rule applies only to people who dropped family coverage and then want it reinstated at a later date. Individuals can change to family coverage at any time.

HOW TO FILE A CLAIM

Step 1 - Claim forms may be obtained online at www.bronxvilleteachers.org
(under Bronxville Benefit Trust).

Step 2 - Complete the "Patient" statement in full. (If all questions are not answered, it will be necessary to return the claim form, thus delaying payment.)

Step 3 - Have your dentist complete her/his portion of the claim form or attach his statement of services to the claim form. (Note: claim detail must appear on doctor's statement).

Step 4 - Send to:

Preferred Group Plans,
Inc. PO Box 15136
Albany, N.Y. 12212-5136

NOTE: SEND ALL CLAIM FORMS PROMPTLY. CLAIM FORMS MUST BE FULLY COMPLETED BY ALL PARTIES INVOLVED AND SUBMITTED WITHIN 90 DAYS FROM THE CLOSE OF THE FISCAL YEAR. IMPROPERLY COMPLETED FORMS WILL CAUSE A DELAY IN THE PAYMENT OF A CLAIM. Proper consideration can only be given to a claim when the completed form is received.

All claim inquiries should be directed to Preferred Group Plans, Inc.

Office hours are: 8:00 AM to 5:00 PM.
Telephone number is 1-800-573-7474

SHOULD BENEFITS BE DETERMINED BEFORE TREATMENT STARTS?

One of the advantages of our dental plan is that it enables you to see the amount payable by the plan prior to having your dentist begin any extensive treatment. This procedure is known as a Pre-determination of Benefits. Through this process, you can prevent any misunderstanding as to what is covered by the dental plan. **Benefits should be pre-determined before you begin treatment if the charges for the treatment will be more than \$400.00.** Benefit determination will be made by the Claims Administrator. Our standard dental claim form should be completed and submitted to the Claims Administrator. The Claims Administrator will advise you and your dentist of the approved covered dental procedures.

COMMON CLAIM PROBLEMS

- Incomplete information regarding whether you or your spouse has other group insurance coverage, and if so, name of group, name of insurance company, address, policy number, etc. If there is other group coverage, send a copy of the benefit payment record furnished by the other plan.
- Incomplete information regarding dates of birth of age.
- Unsigned claim forms, missing procedure codes.
- Failure to submit full-time student verification.
- Failure to submit claims within 90 days of end of plan year.
- Failure by dentist to provide age of prior placement when seeking replacement of crown, denture, or fixed bridgework.

COORDINATION OF BENEFITS PROVISION

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

For purposes of coordinating benefits of multiple coverage, “other plans” means any plan of dental coverage provided by:

- (1) group insurance or any other arrangement of coverage for individuals in a group which provides dental benefits or services on an insured or an uninsured basis;
- (2) “no fault” automobile insurance which is required under any law and is provided on other than a group basis; or
- (3) plans provided by the U.S. Government, State Government or any instrumentalities thereof.

In coordinating the benefits for a Participant having multiple coverage, the “primary” plan pays first and the “secondary” plan pays next to make up the difference, but the total benefit paid by both the primary and the secondary plans will not exceed 100% of the allowable expenses incurred. In addition, no plan will pay more benefits than it would normally provide without this special coordinating provision. In determining which plan is primary and which plan is secondary, the following order will be used: (The determinations that follow are the same as they appear in the booklet describing *Health Benefits For You and Your Dependents*. The wording is taken from that booklet.)

- (1) A plan without a coordination of benefits provision will always be the primary plan; and
- (2) If all plans have a coordination of benefits provision then:
 - (a) The plan covering the Participant as an Employee is primary;
 - (b) The plan covering the Participant as a Dependent Spouse is secondary;
 - (c) Covered Dependent Child - Parents NOT Separated or Divorced -
The benefits of a Plan which covers a child as a Covered Dependent of a parent whose birthday falls earlier in the year are determined before those of a Plan of the parent whose birthday falls later in the year. A person’s year of birth is not relevant in applying this rule. If the other Plan does not have this rule but instead has a rule based on the gender of a parent, and as a result the Plans do not agree on the order of benefits, then the rule in the other Plan will determine the order of benefits.

COORDINATION OF BENEFITS PROVISION

(CONT'D)

- (d) Covered Dependent Child - Parents Separated or Divorced -
The benefits of a Plan that covers a child as a Covered Dependent of divorced or separated parents are determined in the following order:
- (1) the benefits of the Plan of the parent with custody of the child are determined first;
 - (2) the benefits of the Plan of the spouse of the parent with custody of the child (the stepparent) are determined next;
 - (3) the benefits of the Plan of the parent not having custody are determined last. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
 - (4) the benefits of a Plan which covers a person as an Insured Person (or a Covered Dependent of such Insured Person) who is not laid off or retired are determined before the benefits of a Plan which covers such person (or dependent of such person) as a laid off or retired employee. If the other Plan does not have this rule and as a result the Plans do not agree on the order of benefit, this rule is ignored.
 - (5) If none of the above rules determine an order of benefits, then the benefits of a Plan that covered the person for the longer period of time are determined before those of the Plan that has covered the person for the shorter period of time.

Information necessary to the administration of the coordination of benefits provision, for an individual having multiple coverages, is required at the time a claim is submitted.

DESCRIPTION OF DENTAL BENEFITS

The benefits hereinafter set forth are payable, subject to the other provisions and limitations of the plan, "Covered Dental Services."

A. Amount of Benefits

When an eligible Participant and his/her lawful dependents have incurred charges for services, supplies or treatment furnished, the Fund will pay an amount of benefits up to the scheduled allowance.

B. Maximum Benefits

Benefits payable to an eligible Participant will be limited in any one fiscal year (see Schedule of Benefits Supplement). The lifetime maximum for orthodontic benefits is **NOT** included in the plan year maximum.

BENEFIT DETERMINATION

Treatment will be considered to have been performed for the listed procedure as follows:

- (1) Dentures, full or partial - when the impression is taken for the appliance
- (2) Fixed bridgework, crowns and gold restorations - when the tooth is first prepared.
- (3) Root canal therapy - when the tooth is opened.
- (4) Orthodontics - when the first appliance is installed.

LIMITATIONS AND EXCLUSIONS APPLICABLE TO DENTAL BENEFITS

“Covered Dental Charges” shall in no event be deemed to include expenses incurred for the service, supplies or treatment:

- (1) Unless such services, supplies or treatment were prescribed as necessary by a dentist or a physician.
- (2) In a Veteran’s Administration Hospital, or which in the absence of coverage, would have been furnished without cost, or which are furnished under conditions where the Covered Individual has no legal obligations to pay, or if the expenses are reimbursable by a local or other governmental agency, or
- (3) Covered under any group program or union, employer or association program to the extent that more than 100% recovery by the participant would be made for any charges for which benefits are provided hereunder.
- (4) Covered under the U.S. Social Security Act (Title XVIII) as amended from time to time.
- (5) If they were incurred on account of:
 - (a) war, declared or undeclared, including armed aggression.
 - (b) services, supplies or treatment received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group.
 - (c) services or treatment performed by a member of the Participant’s immediate family.
 - (d) loss or theft of dentures or bridgework.
 - (e) dentistry for cosmetic purposes, exclusive of orthodontia, including the alteration or extraction and replacement of sound teeth for the purpose of changing appearance.
 - (f) bodily injury arising out of and in the course of employment by any employer, or disease or defect with respect to which benefits are payable under any Workmen’s Compensation or Occupational Disease Act or Law.
 - (g) services you would not normally be required to pay in the absence of coverage.
- (6) Where the Plan document indicates time restrictions, the Trust will not waive these restrictions under any circumstances.
- (7) Crowning of teeth for periodontal support is not covered.
- (8) Temporary services are not covered expenses.

COVERED DENTAL SERVICES

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

A. Preventive Treatment

- (1) Cleaning of teeth (prophylaxis) and examination are covered three times during each fiscal year. When a perio-scaling is performed on the same date that a prophylaxis is done, an allowance equal to the perio-prophylaxis will be applied. Preventive periodontal maintenance will be counted on the basis of three per fiscal year, collectively with prophylaxis.
- (2) A fluoride treatment will be covered twice each fiscal year for children.
- (3) Space maintainers.

B. Emergency Treatment

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

C. Diagnostic Services

The Plan covers oral examinations, X-rays and laboratory tests that may be necessary to diagnose a specific symptom. The Plan will cover no more than four (4) X-rays for any one oral examination. However, a full mouth X-ray of all teeth taken as part of a general examination is covered once in a three-year period.

D. Anesthetics

A separate charge for general anesthesia is covered in conjunction with oral surgery, periodontics, fractures or dislocation. A charge for local anesthesia is not covered, as it is included within the normal charge for the treatment for which the local is given.

E. Drugs

The Plan covers charges for injectable antibiotics administered by a dentist or physician.

F. Extractions and Oral Surgery

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

G. Fillings and Crowns

The Plan covers fillings and crowns that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury. This includes all silver (amalgam), porcelain and plastic restorations. Crowns and gold fillings are also covered if the tooth cannot be reconstructed by a filling or other material. Allowances for occlusal adjustment are covered once per quadrant per fiscal year. Crowns are not covered within five (5) years of prior placement. Fillings involving the same surfaces are not covered within two (2) years of date of service. Crowns are not covered for 18 months for all new members of the Plan. NOTE: The Plan will cover porcelain gold crowns as well as composite fillings on molars. The Plan may request certification of oral health prior to placement of a crown.

H. Periodontal Services

The Plan covers necessary periodontal treatment. Subgingival curettage and Periodontal Scaling/Root planing are covered by the quadrant with one service treatment per quadrant per year. Periodontal prophylaxis will be applied toward the heading of preventive treatment. Major periodontal work must be pre-approved with supporting X-rays and charting. Osseous surgery will not be covered within five years of the last treatment date.

I. Root Canal Therapy

The Plan covers root canal and other endodontic treatment.

J. Orthodontics

The Plan considers a full orthodontic case to involve the full banding of the upper and lower teeth. All maximums will apply to this type of orthodontic procedure. All procedures less than a full banded case will be assigned a half-case allowance, which will constitute a maximum of 50% of the total life-time allowance by the Plan.

Child Orthodontia – (up to age 18) See Schedule of Benefits Supplement for maximum benefit.

Adult Orthodontia - Class II and Class III cases are covered by pre-approval with X-rays and models, or by submitting to a visual examination. Class I cases will be covered under limited circumstances but must also be pre-approved.

K. Prosthetic Appliances

The Plan covers prosthetic appliances (full denture, partial removable or fixed bridgework). The Plan will not cover the initial placement of appliances involving teeth extracted prior to coverage. However, the Plan will cover dentures or fixed bridges that replace an existing appliance even if the teeth are not extracted while covered, if the prior appliance is more than five years old and cannot be made satisfactory. Where teeth are being replaced within the same arch, but not within the same quadrant, an allowance for a partial will be made and not for fixed bridgework. The Plan also includes benefits for repairing damaged dentures or adding teeth to existing dentures or rebasing the denture. If the Plan pays for a new denture, it will not also cover the repair or rebasing of an old set of false teeth. Relines are not covered within the first six months from date of placement and are not covered more often than once per fiscal year. The Plan may request certification of oral health prior to placement of any prosthetic appliance.

DEFINITIONS

A. DENTIST - The term “dentist” shall be deemed to mean a Doctor of Dental Surgery or Doctor of Medical Dentistry.

B. DENTAL SERVICE - The term “dental service” means any service listed in the Schedule of Covered Dental Services when performed by or under the direction of a licensed dentist.

C. COVERED DENTAL EXPENSE - Means the expenses actually incurred for charges made by a dentist for the performance of a dental service when such service is essential for the necessary care of the teeth.

D. FISCAL YEAR - July 1 - June 30

PARTICIPATING DENTAL PROVIDER PROGRAM – See Bronxville Benefit Trust website: www.bronxvilleteachers.org / Bronxville School Trust

SELF-FUNDED VISION CARE PROGRAM

ELIGIBILITY

An employee becomes eligible to receive benefits under the Vision Plan in accordance with the eligibility rules set forth on pages 1 and 2. Individual coverage is provided to eligible employees at no cost. Members are required to contribute toward the cost of family coverage. **If family coverage is dropped and then reinstated at a later date, there is a waiting period of 24 months for dependent coverage.** This rule applies only to people who dropped family coverage and then want it reinstated at a later date. Individuals can change to family **coverage at any time.**

COVERED SERVICES

The Trust will pay for services listed in the Schedule of Benefits Supplement.

HOW TO FILE A CLAIM

Step 1 - Obtain claim form online at www.bronxvilleteachers.org (under Bronxville School Trust).

Step 2 - Complete the “Patient” statement in full. (If all questions are not answered, it will be necessary to return the claim form, thus delaying benefit payment).

Step 3 - Have your eye doctor complete his/her portion of the claim form or attach the statement of services to the claim form. (Note: claim detail must appear in doctor’s statement.)

Step 4 - You are to review the claim form for completeness and the send your claim form to:

Preferred Group Plans, Inc.
PO Box 15136
Albany, N.Y. 12212-5136

NOTE: Send all claim forms promptly. Claim forms must be fully completed by all parties involved and submitted within 90 days from the treatment completion date. Improperly completed forms will cause a delay in the payment of a claim.

PARTICIPATING PROVIDER VISION PROGRAM – See details on the website under “General Coverage Information”.

BRONXVILLE PUBLIC SCHOOL EMPLOYEE BENEFIT TRUST

GROUP LEGAL SERVICES PLAN

June, 2015

COVERAGE:

The plan covers the plan member, spouse, children to the age of 19, living at home, or dependent children in school and not gainfully employed to age 25. The plan is limited to the practice of law in the States of New York, Connecticut and New Jersey and within a 50-mile radius of Bronxville, New York.

INCLUDED SERVICES:

1. Consultation and Advice (in office or by phone)
 - a. Any personal matter
 - b. Any business matter
2. Simple Document Preparation or Review (personal non-business matters):
 - a. Loan Agreements
 - b. Contracts to buy or sell personal property, e.g.: automobiles
 - c. Installment sale contract, e.g.: to purchase household furnishings
 - d. Leases
3. Correspondence and Telephone Communication to Third Parties (personal non-business matters), e.g.:
 - a. Property damages claims, e.g.: automobile accidents
 - b. Consumer problems, e.g.: defective products or services
 - c. Negotiation of debt repayment obligations
 - d. Protection against improper debt collection practices
 - e. Landlord/Tenant problems
4. Purchase and sale of house, condominium or cooperative apartment (Member's primary residence)
5. Simple Will for member and spouse
6. Living Will, Medical Care Proxy
7. General Power of Attorney
8. Initial appearance at Criminal and Family Court (Emergency night telephone number is provided below)

MATTERS NOT COVERED

1. Anything not specifically included in plan
2. Claims between members of the plan
3. Claims between the member, spouse, or dependent and the Trust Fund, the Association or the School District or arising under the Collective Bargaining Agreement
4. Matters currently with another attorney
5. Unmeritorious or spite claims
6. Litigation before any Court or Administrative Tribunal

REDUCED FIXED FEE SCHEDULE FOR NON-INCLUDED SERVICES:

1. Purchase or sale of house, condominium or cooperative apartment (non-primary residence): .5% of price (minimum \$500: maximum \$1,250)
2. Traffic Court matters: \$150 per pre-trial Court appearance: trial by agreement
3. Administration or Probate of Estate: 2.5% of gross estate (minimum \$1,000)
4. Name change: \$500
5. Uncontested Adoption: \$500
6. Uncontested Divorce or Uncontested Separation Agreement (excludes negotiation): \$750
7. Uncontested Personal Bankruptcy: \$2,500
8. Personal injury actions: 25% contingency fee
9. Business and personal matters not set forth in the Fixed Fee Schedule: Fees shall be mutually agreed to by the attorney and client

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

HAROLD, SALANT, STRAFFIELD & SPIELBERG
81 Main Street
White Plains, New York 10601
Tel: (914) 683-2500 Ext. 310; Fax: (914) 683-1279
(Christopher Harold's Cell Telephone Number,
For Emergency Use Only:
Cell (914) 420-8636)

SELF-INSURED DISABILITY

ELIGIBILITY

An employee becomes eligible to receive benefits under the Self-Insured Disability Plan in accordance with the eligibility rules set forth on pages 1 and 2. Individual coverage is provided to eligible employees at no cost.

COVERAGE

The elements of the plan are as follows:

- a. benefit of \$1,000 per month;
- b. payable upon qualification for social security disability;
- c. in effect for three years;
- d. no offsets;
- e. evidence of continued qualification to be provided by the member three times a year;
- f. plan administration by The Preferred Group

LIFE and AD&D INSURANCE

**Provided by Guardian
The Guardian Life Insurance
Company of America
7 Hanover Square
New York, New York 10004-2616**

Each eligible employee receives life insurance coverage under a group plan provided contractually by the Board of Education and administered by the Trust. There is a separate booklet explaining this program. Coverage under this Plan begins with the effective date of employment. If an employee chooses to elect less than the full coverage offered at the time of initial employment, the employee will have to complete an "Evidence of Insurability" in order to increase coverage at a future date. This must be submitted to and approved by the insurance company before any increases will be allowed. The policy ends when an employee leaves active employment in the Bronxville School District other than for retirement.

Each eligible employee who meets the definition for a retiree set forth on page 2 is entitled to take into retirement one-half of the face value of the basic policy. No portion of any supplementary policy may be taken. At age 70, the face value of the policy is reduced to \$2,000 and the premium is appropriately adjusted.

At the termination of employment, time of retirement, age 70 or when a decrease in life coverage occurs, the employee has the option to convert any lost coverage into a whole life policy without medical evaluation. The increased premiums would be the responsibility of the employee.

An addendum to the life insurance policy is an Accidental Death and Dismemberment policy. This added insurance will pay a sum of money if certain injuries or death result from an accident. A separate rider explaining this feature is available. A.D.&D. coverage ceases at the termination of employment for any reason.

GENERAL INFORMATION CONCERNING PLAN COVERAGE

The benefits provided by this Plan are for reimbursement of incurred expenses, and payment by the Plan will be made only for those costs actually incurred and paid for by the eligible Participant. Reimbursement will not be made for any amounts for which the Participant is not legally liable in the absence of coverage by this Plan. The Plan will not cover a procedure which has already been covered under the Major Medical program.

This booklet describes the main features of the Plan. The benefits provided may be changed by the Board of Trustees and are reflected in the Schedule of Benefits Supplement. All provisions of the Plan are subject to such rules and regulations adopted by the Trustees.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

TO: Participants in health plans sponsored by Preferred Group Plans, Inc.
FROM: Plan Administrator

The health plan options sponsored by Preferred Group Plans, Inc. (referred to this Notice as the “Health Plan” may use or disclose medical information about participants (employee and their covered dependants) as required for purposes of administering the Health Plans, such as for reviewing and paying claims, utilization review. Regardless of who handles medical information for the Health Plans, the Health Plans have established policies that are designed to prevent the misuse or unnecessary disclosure of protected health information.

Please note that the rest of this Notice uses the capitalized word, “Plan” to refer to each Health Plan sponsored by the Bronxville Public School Employees’ Benefit Trust including any trustees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. Health Plan means, for purposes of this notice, medical, dental, vision, and other coverages that meet the definition of Health Plan container in HIPAA.

As required by Federal Law, this Notice is being provided to you to describe the Plan’s health information privacy procedures and policies. It also provides details regarding certain rights you may have under Federal Law regarding medical information about you that is maintained by the Plan.

You should review this Notice carefully and keep it with other records relating to your health coverage. The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning April 14, 2003 and will remain in effect until it is revised.

If the Plan’s health information privacy policies and procedures are changed so that any part of this Notice is no longer accurate, the Plan will provide a new updated Privacy Notice. The Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies were revised.

Protected Health Information

This Notice applies to health information held by the Plan that includes identifying information about you (or your dependents). Such information, regardless of the form in which it is kept, is referred to in this Notice as Protected Health Information or “PHI”. For example, any health information that includes details such as your name, street address, a date of birth or social security number is PHI. However, information that does not include such obvious identifying details is also protected.

Health Information if that information, under the circumstances, could reasonably be expected to allow the person who is reviewing that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and such information may be used for any purpose that is consistent with applicable law and with the Plan’s policies and requirements.

How the Plan Uses or Discloses Protected Health Information

Protected Health information may be used or disclosed by the Plan as necessary for the operation of the Plan. Specifically, PHI may be used or disclosed for the following Plan purposes.

Treatment: If a provider who is treating your requests, any part or all of your health care records that the Plan possesses, the Plan generally will provide the requested information.

Payment: If the plan needs PHI to review a claim or to make a payment to a provider or for similar payment-related purposes, the Plan may use that information (or will request that information, if it does not already possess it) and will review the information for payment purposes.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (continued)

Other Health Care Operations: The Plan may also use PHI as needed for various purposes that are related to the operation of the plan. These purposes include utilization review programs, quality assurance review, contacting providers or participants regarding treatment alternatives, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan.

Use or Disclosure Required by Law: To the extent that the Plan is legally required to provide Protected Health Information to a government agency or anyone else, it will do so. In such cases, the Plan will make reasonable efforts avoid disclosing more information that is required by applicable law.

Disclosure for Public Health Activities: The Plan may disclose PHI to a public health authority that is authorized to collect such information (or to a foreign government agency, at the direction of a public health authority) for purposes of preventing or controlling injury, disease or disability.

The Plan may also disclose PHI to a public health authority or other government agency that is responsible for receiving reports of child abuse or neglect.

In addition, certain information may be provided to pharmaceutical companies or other businesses that are regulated by the Food and Drug Administration (FDA), as appropriate for purposes relating to the quality, safety and effectiveness of FDA-regulated products.

Also, to the extent permitted by applicable law, the Plan may disclose PHI, as part of a public health investigation or intervention, to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

Disclosures about victims of abuse, neglect or domestic violence: (The following does not apply to disclosures regarding child abuse or neglect, which may be made only as provided under Disclosure for public health activities).

If required by law, the Plan may disclose PHI relating to a victim of abuse, neglect or domestic violence, to an appropriate government agency. Disclosure will be limited to the relevant required information. The Plan will inform the individual if any PHI is disclosed as provided in this paragraph or the next one.

If disclosure is not required by law, the Plan may disclose relevant PHI relating to a victim of abuse, neglect or domestic violence to an authorized government agency, to the extent permitted by applicable law, if the Plan determines that the disclosure is necessary to prevent serious harm to the individual or to other potential victims. Also, to the extent permitted by law, the Plan may release PHI relating to an individual to a law enforcement official, if the individual is incapacitated and unable to agree to the disclosure of PHI and the law enforcement official indicates that the information is necessary for an immediate enforcement activity and is not intended to be used against the individual.

Health Oversight Activities: The Plan may disclose Protected Health Information to a health oversight agency (this includes Federal, State or local agencies that are responsible for overseeing the health care system or a particular government program for which health information is needed) for oversight activities authorized by law. This type of disclosure applies to oversight relating to the health care system and various government programs as well as civil rights laws. This disclosure would not apply to any action by the government in investigating a participant in the Plan, unless the investigation relates to the receipt of health benefits by that individual.

Disclosure for Judicial and Administrative Proceedings: The Plan may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order from a court or an administrative tribunal. Also, if certain restrictive conditions are met, the Plan may disclose PHI in response to a subpoena, discovery request or other lawful process. In either case, the Plan will not disclose PHI that has not been expressly requested or authorized by the order or other process.

Disclosures for Law Enforcement Purposes: The Plan may disclose Protected Health Information for a law enforcement purpose to a law enforcement official if certain detailed restrictive conditions are met.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (continued)

Disclosures to Medical Examiners, Coroners and Funeral Directors Following Death: The Plan may disclose Protected Health Information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

Disclosures for Organ, Eye or Tissue Donation Purposes: The Plan may disclose Protected Health Information to organ procurement organization or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Disclosures to avert a serious threat to health or safety: The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose Protected Health Information, (1) if it believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.

Disclosures for Specialized Government Functions: If certain conditions are met, the Plan may use and disclose the Protected Health Information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.

The Plan may also or disclose PHI to authorize federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities or for the provision of protective services to the President or other persons as authorized by Federal law relating to those protective services.

Disclosures for Workers' Compensation Purposes: The Plan may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Uses and Disclosures Not Mentioned Above: Authorization Require

The Plan will not use or disclose Protected Health Information for any purpose that is not mentioned above, except as specifically authorized by you. If the Plan needs to use or disclose PHI for a reason not listed above, it will request your permission for that specific use and will not use PHI for that purpose except according to the specific terms of your authorization. You may complete an Authorization Form if you want the Plan to use or disclose health information to you, or to someone else at your request, for any reason.

Any authorization you provide will be limited to specified information, and the intended use or disclosure as well as any person or organization that is permitted to use, disclose or receive the information must be specified in the Authorization Form. Also, an authorization is limited to a specific limited time period and it expires at the end of that period. Finally, you always have the right to revoke a previous authorization by making a written request to the Plan. The Plan will honor your request to revoke an authorization but the revocation will apply to any action that the Plan took in accord with the authorization before you informed the Plan that you were revoking the authorization.

Your Health Information Rights

Under Federal Law, you have the following rights:

You may request restrictions with regard to certain types of uses and disclosures: This includes the uses and disclosures described above for Treatment, Payment and other health plan operations purposes. If the Plan agrees to a restriction you request, it will abide by the terms of that restriction. However, under the law, the Plan is not required to accept any restriction. If the Plan determines that a requested restriction will interfere with the efficient administration of the Plan, it may decline the request.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (continued)

If PHI is being provided to you, you may request that the information be provided to you in a confidential manner: This right applies only if you inform the Plan in writing that the ordinary disclosure of part or all of the information might endanger you. For example, an individual may not want information about certain types of treatment to be sent to his or her home address because someone else who lives there might have access to it. In such a case, the individual could request that the information be sent to an alternate address. The Plan will honor such requests as long as they are reasonable, but the Plan reserves the right to reject a request that would impose too much of an administrative burden or financial risk on the Plan.

You may request access to certain medical records possessed by the Plan and you may inspect or copy those records: This right applies to all enrollment, claims processing, medical management and payment records maintained by the Plan and also to any other information possessed by the Plan that is used to make decisions about you or your health coverage.

You may request that Protected Health Information Maintained by the Plan be amended: If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be amended. The Plan may reject your request if it finds that the information is accurate and complete. Also, if the information you are challenging was created by some other person or organization, the Plan ordinarily would not be responsible for amending that information unless you provide sufficient information to the Plan to establish that the originator of the information is not in a position to amend it.

The Plan normally will respond to a request for an amendment within 60 days after it receives your request. In certain cases, the Plan may take up to 30 additional days to respond to your request.

If the Plan denies your request, you will have the opportunity to prepare a statement to be included with the health records to explain why you believe that certain information is incomplete or inaccurate. If you do prepare such a statement, the Plan will provide that statement to any person who uses or receives the information that you challenged. The Plan may also prepare a response to your statement and that response will be placed with your records and provided to anyone who receives your statement. A copy will also be provided to you.

You have the right to receive details about certain non-routine disclosures of health information made by the Plan: You may request an accounting of all disclosures of health information with certain exceptions. This accounting would not include disclosures that are made for Treatment, Payment and other health plan operation purposes, disclosures made pursuant to an individual authorization from you, disclosures made to you and certain other types of disclosures. Also, your request will not apply to any disclosures made before April 14, 2003 or for any period earlier than 6 years from the date your request is properly submitted to the Plan. You may receive an accounting of disclosures once every 12 months at no charge. The Plan may charge a reasonable fee for any additional requests during a 12-month period.

You have the right to request and receive a paper copy of the Privacy Notice: If the Plan provides this Notice to you in an electronic form, you may request a paper copy and the Plan will provide one.

Health Information Complaint Procedures

If you believe your health information privacy rights have been violated, you may file a complaint with the Plan. To file a complaint, you should contact Preferred Group Plans, Inc, P.O. Box 15136, Albany, New York 12212-5136. In addition to your right to file a complaint with the Plan, if you feel your privacy rights have been violated, you may file a complaint with the U.S. Department of Health & Human Services. You will never be retaliated against in any way as a result of any complaint that you file.

PREFERRED GROUP PLANS, INC.
P.O. Box 15136
Albany, NY 15136
(518) 641-0321
1-800-573-7474

