D F U T

Dobbs Ferry United Teachers

Updated 07/09/2024

Welfare Fund

505 Broadway, Dobbs Ferry, New York 10522

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DOBBS FERRY UNITED TEACHERS WELFARE FUND

Dobbs Ferry United Teachers Welfare Fund

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FUND ADMINISTRATORS

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CERTIFIED PUBLIC ACCOUNTANT

WEAVER
1 Pennsylvania Plaza, Suite 3200
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Dear Member:

This booklet is an important source of information. It describes the eligibility requirement and how claims should be submitted for benefits. We urge you to familiarize yourself with the benefits program and the required procedures so that you understand your rights and obligations under the program.

Your Trustees are proud to provide you with these extensive benefit programs in our continuing effort to bring better benefits to each of you.

The following are the **DFUT Welfare Fund Benefits**:

- **DENTAL PLAN**
- **OPTICAL PLAN**
- **EMPLOYEE ASSISTANCE PROGRAM**
- **DEATH BENEFIT PLAN**
- **PRESCRIPTION PLAN**
- **MEDICAL REIMBURSEMENT PLAN**
- **HEARING AID BENEFIT**
- **LEGAL SERVICES PLAN**

BENEFIT TERMS

The benefits of the DFUT Welfare Fund Plan begin January 1st through December 31st, with the exception of dental coverage. The plan year for dental coverage is July 1st through June 30th. If there are any questions, please do not hesitate to contact a Trustee, or our administrator, DH Cook, at (212) 505-5050.

GENERAL INFORMATION

What is the Fund?

The Dobbs Ferry United Teachers Welfare Fund is a legal entity separate and distinct from the Union and the District and was established as a result of collective bargaining between the Board of Education and the DFUT.

Who is responsible for the Fund's operations?

The Fund is governed by a board of Trustees who are designated by the DFUT in accordance with its Agreement and Declaration of Trust by which the Fund was created. The Trustees are elected by the DFUT Executive Board and include the DFUT President.

The Board of Trustees retains Daniel H. Cook Associates, Inc. as Fund Administrators who are responsible for processing claims for benefits.

Do the contributions to the Fund become part of the general treasury of the union?

No. The Dobbs Ferry United Teachers and the DFUT Welfare Fund are two (2) distinct and separate legal entities. Their resources are not co-mingled.

What becomes of the contributions that the School District makes to the Fund?

Under the Agreement and Declaration of Trust, contributions to the Fund are used to provide benefits for covered members and their families and to finance the cost of administration.

Does the Fund operate under ERISA?

No. The Fund is not subject to the provisions of the Employees Retirement Income Security Act of 1974 (ERISA).

Does the Fund operate under the Supervision of the New York State Insurance Department?

No. The Fund is not within the jurisdiction of the New York State Insurance Department as it is a unilaterally operated trust fund, administered by union trustees only.

Who is covered?

All full time employees of the Board of Education of Dobbs Ferry, defined as full time teachers, nurses, physical therapists, occupational therapists, clericals, custodial, administration, teaching assistants and their eligible dependents are covered by the Welfare Fund. **Part-time employees** defined as clerical employees working .58 or teachers working .6 or more per week are provided coverage. Permanent substitutes are not included.

Dependents, as defined by the Fund, are your **spouse, domestic partners (with approved paperwork), unmarried dependent children who have not reached their 19th birthday and unmarried dependent children who are full time students and have not reached their 23rd birthday. Documented proof of eligibility must be submitted at the beginning of every semester.**

Dependent coverage is also extended to any unmarried child, regardless of age, who is incapable of self-sustained employment by reason of physical handicap, mental illness, developmental disability or mental retardation, who became so prior to attainment of age 19 and who resides with and is wholly dependent upon the covered employee for support. The member must submit proof of the dependent child's incapacity to the Fund office. (This must be done 31 days after the date the dependent attains the age at which his or her coverage would otherwise terminate, or 31 days after notification of his or her ineligibility, **whichever is later**). Proof of the continued existence of such incapacity shall be furnished to the Fund office upon request.

In general, subject to the requirements pertaining to the definition of a covered employee, employees are eligible for benefits as long as they are in active status. Active status is determined by the period for which contributions are paid, or should have been paid for the employee by the Board of Education to the DFUT Welfare Fund.

In addition, employees in covered categories on Authorized Leave (for a period not exceeding 26 weeks) will also be considered to be in active status, but only if they are actually disabled and submit proof of it. A copy of the Fund's Leave Disability Claim form must be filed with the Fund office with each claim submitted for payment. (Federal law requires that women affected by pregnancy, childbirth, or related medical conditions must be treated the same as other persons unable to work. Under this law, an employee is not considered disabled merely

because she is pregnant. Disability as a result of pregnancy must be established to the satisfaction of the Fund in the same manner as all other disabilities).

If a covered member dies, benefits can be continued for the remainder of the fiscal year (July 1 – June 30) for his or her eligible dependents through COBRA by reaching out to Cook Associates.

Dependents become eligible for benefits on the same date as the member or, if acquired later, on the date they first become eligible dependents, but no claims will be honored until an appropriate enrollment form is received.

How to Enroll

All covered employees must file an enrollment form with the Fund office before any claims can be paid. The employee is responsible for updating the information on the enrollment form.

If You Leave Employment

Eligible employees who cease employment for reasons of retirement, leave of absence, child bearing or child rearing leave, or other conditions as set forth in the collective bargaining agreement, may continue to remain eligible provided they maintain their membership in the DFUT or its retiree chapter and make contributions to the DFUT Welfare Fund in such amounts as the Trustees may determine.

Once an eligible employee ceases employment for reasons of retirement, leave of absence, child bearing or child rearing leave, or other conditions set forth in the collective bargaining agreement and elects to not maintain membership in the DFUT or its retiree chapter nor make contributions to the Welfare Fund for continuation of benefits, he or she may not thereafter become eligible for benefits unless he or she returns to active employment. As per agreement between the Board of Education and the DFUT, returning members and dependents may be covered.

A retiree/eligible must indicate his or her intention to maintain membership and make appropriate payment within 30-60 days of retirement date.

Provisions of Coverage

Except for the Death Benefit, the DFUT Welfare Fund benefits are self-insured by the Fund. Our legal services are provided through the NYSUT Legal Plan.

VITAL INFORMATION REQUIRED
FOR CLAIM FORMS AND CORRESPONDENCES

All claims received by the DFUT Welfare Fund must be submitted on the appropriate claim forms. An incomplete claim form will be returned to the member for further information, which may cause a delay in the benefit payment.

In Addition

- When any change occurs in your status – marriage, divorce, separation, birth or adoption of a child, death of an eligible dependent, or a change in the beneficiary of your death benefit, please notify the Fund office. It is important that you keep the Fund office up to date on your current status so that claims can be processed efficiently consistent with our policy of prompt payment.

  IF YOU FAIL TO TIMELY NOTIFY THE FUND OF A CHANGE IN FAMILY STATUS AND YOUR FORMER ELIGIBLE DEPENDENT INCURS CLAIMS PAID FOR BY THE FUND, YOU WILL BE HELD FINANCIALLY RESPONSIBLE FOR REPAYMENT OF THOSE CLAIMS TO THE FUND.

- Members will receive a confirmation email when new enrollment forms are received by the Fund indicating enrollment or changes to enrollment. It is the member's responsibility to keep his/her status up to date and follow up if confirmation is not received within 7 days of being sent.

- Information, literature and claim forms are available on the Dobbs Ferry School District webpage or at DHCook.com.

RIGHT TO APPEAL

The Board of Trustees may change the benefits provided by this Fund. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are

subject to such rules and regulations and to the Trust Indenture, which established and governs the Fund's operations.

The Fund office uniformly applies all rules. The action of the Fund office is subject only to review by the Board of Trustees. An employee, eligible dependent or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees, DFUT Welfare Fund. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

OVERPAYMENT OF BENEFITS/FUTURE OFFSET

In the event you receive an overpayment of Fund benefits, on your behalf or on behalf of your dependent, you are obligated to refund said overpayment to the Fund immediately. In the event you fail to refund said overpayment, you are subject to an offset against future benefits until said overpayment is fully recouped, or a suspension of your benefits, until said overpayment is paid in full. Such offset and/or suspension may be applied to the member's and/or eligible dependents' benefits. An overpayment includes, but is not limited to, any payment made on claims submitted by individuals who are no longer eligible for benefits (e.g. a divorced spouse of a member who did not elect to continue coverage under COBRA as well as the payment of the wrong amount on any claim.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured though the acts or omissions of a third party, the Fund shall be entitled – to the extent it pays out benefits – to reimbursement from the covered member or dependent from any recovery obtained. Alternatively, the Fund shall be subrogated unless otherwise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim for recovery against the third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

1. To reimburse the Fund, to the extent of benefits paid by it, out of any money recovered from such third party, whether by judgment, settlement or otherwise;
2. To provide the Fund with an assignment of Proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund on seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services;

3. To take all reasonable steps to affect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Federal law requires that most group health plans (including the Dobbs Ferry United Teachers Welfare Fund) give employees (known as "members" in the case of the Fund) and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan (in this case, the Fund's plan of benefits under which the individual was covered). Depending on the type of qualifying event, "qualified beneficiaries" can include the employee/member covered under the Fund's plan, the covered employee's/member's spouse/domestic partner, and the dependent children of the covered employee/member.

Continuation coverage is the same coverage that the Fund's plan gives to other members or eligible dependents that are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other members or eligible dependents covered under the Fund's plan. **Continuation coverage applies to the Fund's dental, optical, prescription drug co-pay reimbursement, medical reimbursement and hearing aid benefits programs.**

COBRA continuation coverage is administered by the Fund's Administrator, Daniel H. Cook Associates, Inc. 253 35th Street, 12th Floor, New York, New York 10001, telephone number (212) 505-5050.

The following language is required by the federal health care law. The Fund cannot represent whether or not dental, vision or coverage similar to the Fund's other supplemental medical programs is available through the health care exchanges.

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.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through 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.

How long will continuation coverage last?

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred.

In the case of a loss of Fund coverage due to end of employment or reduction in hours of employment with BOCES, the employer must notify the Fund Administrator that the qualifying even has occurred and coverage generally may be continued only for us to a total of 18 months.

In the case of losses of coverage due to a member's/employee's death, divorce or legal separation, the member's/employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Fund's plan, the member must notify the Fund Administrator (Daniel H. Cook Associates, Inc., 253 35th Street, 12th Floor, New York, New York 10001) that the qualifying event has occurred and coverage may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the member's/employee's hours of employment with the Board of Education of Dobbs Ferry, and the member/employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the member/employee lasts until 36 months after the date of the Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium for continuation coverage is not paid to the Fund in full and on time.
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary.
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or

- The Fund ceases to provide any health related benefits to its members

Continuation coverage may also be terminated for any reason that the Fund would terminate the coverage of a member is not receiving continuation coverage.

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage from the Fund, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Fund's Administrator, Daniel H. Cook Associates, Inc. 253 35th Street, 12th Floor, New York, New York 10001 of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide the Fund's Administrator, Daniel H. Cook Associates, Inc. 253 35th Street, 12th Floor, New York, New York 10001 with a copy of an SSA disability determination letter within 60 days of the determination in order to extend the period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Fund's Administrator of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered member/employee, divorce or separation from the covered member/employee, the covered member's/employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund's plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Fund's plan if the qualifying even had not occurred. You must notify the Fund's

Administrator, Daniel H. Cook Associates, Inc. 253 35th Street, 12th Floor, New York, New York 10001 within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, the Fund's Administrator, Daniel H. Cook Associates, Inc. 253 35th Street, 12th Floor, New York, New York 10001 must be notified that a qualifying event has occurred and you must then complete the Fund's **Continuation Coverage Election Form** and furnish it according to the directions and timeframes indicated on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the member's/employee's spouse may elect continuation coverage even if the member/employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The member/employee or the member's/employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Fund's health-related benefits coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. Under the rules governing the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA) there were limitations on the plan imposing preexisting condition exclusions; however, such extensions became prohibited beginning in 2014 under the Patient Protection and Affordable Care Act (PPACA)

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the Fund for coverage of a similarly situated Fund member or eligible dependent who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

COORDINATION OF BENEFITS

Benefits Provision:

1. If you are a covered member of the Fund, and are eligible for benefits from another group plan:

   - Submit your claim to the Fund office for **primary coverage**
   - **After you received payment for such claim from the Fund, you may submit this claim to the other group plan under which you are eligible for benefits**
   - **You will receive any additional benefits, which may be due for this claim under the second plan, but the total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of all allowable expenses**.

2. If your spouse has a claim and is eligible for benefits under another group plan:

   - He/She must submit the claim to his/her plan first
   - After the claim is paid by that plan, it may be submitted to this Fund accompanied by the breakdown of monies received from the other plan (Explanation of Benefits)
   - Any additional benefits, which may be due for this claim, will be paid by this Fund, but the total amount paid for each claim from any group plan under which your dependent is eligible and from this Fund cannot exceed 100% of all allowable expenses.

3. If a claim is submitted for a child when one parent is a covered member of this Fund and the other parent is a covered member of another plan:

   - Submit this claim to the Plan that covers the parent whose birthday comes first in the calendar year (month and day only)
     This is referred to as the "Birthday Rule"

- After the claim has been paid by the first plan, it may be submitted to the second plan along with a breakdown of monies received from the first plan
- The payment you receive for each claim from both plans cannot exceed 100% of allowable expenses.

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires the Welfare Fund to protect the confidentiality of your private health information.

The Fund will not use or further disclose information that is protected by HIPAA (protected health information), except as necessary for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe HIPAA's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Fund or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

DENTAL PLAN

HOW OUR GROUP DENTAL BENEFIT PLAN WORKS

Actively employed members may decline coverage of Fund dental benefits for themselves or any covered dependent by completing a Declination of Coverage form, which can be obtained by contacting the Fund Administrator. Since Fund benefits for actively employed members are funded exclusively by collectively bargained employer contributions, you will not receive a rebate or other compensation if you decline dental benefits for yourself or any covered dependent.

- You or your eligible dependent select the dentist of your choice. A dental list is available with dentists who accept our payment
- You are not limited to certain dentists. You may change dentists at your convenience without endangering your benefits.

What Benefits are Paid?

The Dental Plan will pay a total maximum benefit of $3,500.00 per year per covered family. The dental benefit year begins July 1st and ends June 30th.

If two or more dental services are rendered, payment will be made for each dental service unless the Schedule of Maximum Allowances specifies a maximum amount for a particular combination of dental services.

SPECIAL LIMITATIONS APPLICABLE TO SPECIFIC DENTAL SERVICES

All dental benefits are limited as follows:

- They must be recommended and rendered by a duly licensed and practicing dentist
- They must be rendered while coverage is in effect
- They must be listed in the Schedule of Maximum Allowances in order to be covered expenses
- The claim procedures described in "How Benefits are Paid" must be followed.

In addition, certain specific procedures are limited as follows:

- Permanent partial dentures must have a cast steel framework and acrylic attachment

The following procedures are **limited to twice** during any **12-month period**:

- Oral examinations
- Diagnosis and prophylaxis
- Complete intraoral series of periapical X-rays, a complete series of bitewing X-rays limited to one time every 3 years

Crown Restorations

Crown restorations must be associated with dental caries or where physical reconstruction cannot be made by any other type of restoration, except where services are covered under the plan as in fixed bridgework.

Dentures

Dentures are subject to a waiting period of 12 months from your initial eligibility for Fund benefits. Only one complete denture, including an immediate (temporary) denture, either full or partial in any one jaw, will be provided during each 3-year period. (Should include fixed bridgework as well).

Dental Pap Smear or Oral Biopsy

These services are provided under the dental plan only when performed as a preventative measure for detection of oral cancer. If performed because of an actual sickness or disease, benefits for such services must be submitted through your basic health insurance coverage.

EXCLUSIONS

Loss or expense caused by, incurred for, or resulting from the following is **NOT COVERED**:

- Loss caused by acts of war, declared or undeclared or military service: occupational injuries or sickness.
- Services for cosmetic or aesthetic purposes
- Dental procedures not included in the Schedule for Maximum Allowances
- Expenses incurred which you would not be required to pay if there were not insurance coverage
- The replacement of a lost, stolen or mislaid appliance.

When to File A Claim

You should file a dental claim for Dental Expense Benefits as soon as you or one of your eligible dependents incurs expenses.

1. Obtain a claim form online.
2. Complete the member's portion of the claim form, and give it to your dentist.
3. **Mail the claim form to our Fund Administrator's address at the top of the form**.

Claims must be filed within 90 days after commencement of dental procedures.

How Benefits are Paid

Benefits will be paid through the Fund. When benefits would be payable under more than one group plan, benefits payable under those plans will be coordinated to the extent that the total benefits under all group plans will not exceed 100% of the total allowable expenses. "**Allowable expense**" means any necessary, reasonable and customary expense, which is covered in whole or in part under at least one of those group plans.

OPTICAL PLAN

Actively employed members may decline coverage of Fund optical benefits for themselves or any covered dependent by completing a Declination of Coverage form, which may be obtained online. Since Fund benefits for actively employed members are funded exclusively by collective bargaining employer contributions, you will not receive a rebate or other compensation if you decline optical benefits for yourself or any covered dependent.

What Benefits are Paid?

A maximum allowance of $500.00 is provided every year per covered member's family Effective Jan 1st, 2025. This covers services rendered by an optometrist or ophthalmologist of his or her choice for any out-of-pocket expense toward an eye examination, prescription lenses, frames, etc.

How to Receive the Optical Allowance

- Submit a dated bill and Benefits Claim Form to the address at the top of the form.
- All optical benefits must be submitted no later than December 31st.

Limitations

Charges in excess of the above allowance are the responsibility of the member.

Exclusions

Non-prescription glasses and sunglasses

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program is designed to assist all employees and their families when facing a personal crisis. The program provides confidential counseling for physical or psychological problems.

Limitations

Involvement in the program is completely voluntary and all information is confidential.

What Benefits are Paid?

The DFUT Welfare Fund and the District pay an equal share of the outside consulting cost for the program. There is no cost for contacting the program.

How to Receive the Benefit

Call our confidential and private number 1-800-666-5327, and an Employee Assistance Program representative will speak with you. Information can also be found under Human Resources on the district website.

DEATH BENEFIT

Who is Covered?

Only the employees of the DFUFSD are covered for the Death Benefit provided by the DFUT Welfare Fund.

What Benefits are Paid?

This benefit provides $10,000.00 upon death up to the age of 65 of the employee. Between the ages of 65-70, the amount decreases to $6500.00. After age 70, the amount decreases to $5,000.00.

How the Benefits are Obtained

- A member of the family or the beneficiary of the deceased notifies the Fund office of the death of the member.
- A claim form will be sent to the beneficiary to be completed and must be returned with a certified copy of the death certificate (with raised seal).
- A check in the appropriate amount will be sent to the beneficiary by the underwriting insurance company.

Designation of the Beneficiary

The beneficiary is designated on the Fund enrollment form of the DFUT Welfare Fund.

It is important that the designation of the beneficiary be kept up to date. If there is a change in your marital status or if your designated beneficiary should die, designate a new beneficiary promptly by completing a new form. Enrollment forms may be obtained online.

Should the last named beneficiary predecease the employee, or should no beneficiary be named, the Life Insurance which may be payable, will be paid first to the covered employee's surviving spouse, or if none, to his or her surviving children, or if none, to the covered employee's estate.

PRESCRIPTION DRUG COPAY REIMBURSEMENT BENEFIT

What Benefits are Paid?

A benefit allowance of up to $300.00 is provided once every calendar year to cover the cost of any out-of-pocket copay expenses for prescription drugs per covered member or dependents. Once you have incurred $300.00 of out-of-pocket expenses in a calendar year, thereafter, the Fund will reimburse 1% per $1.00 per each additional prescription co-pay expense incurred during the same calendar year. These claims must be submitted by March 1st of the calendar year following the year in which the co-pay expenses were incurred. This benefit covers any out-of-pocket expense for otherwise covered prescription drugs.

Limitation

- Excluded are Over the Counter drugs and drugs not authorized by prescription from a duly certified medical practitioner.
- If you are not employed by the district during the time that the benefit is offered (Jan 1st - March 1st), then you are ineligible for the benefit.
- New hires may only submit receipts from the time they were employed by the district.

How to Receive the Prescription Drug Copay Benefit

- Submit all co-pay receipts for the calendar year to the address at the top of the Benefits Claim form.
- No claim will be accepted for processing and/or payment if not received within 30 days of the filing deadline, which is March 1st of the new calendar year.

- All receipts must include Rx number, name of claimant, date of service and amount paid.

MEDICAL BENEFIT

Who is covered?

All members of the Fund are covered for the Medical Benefit.

What Benefits are Paid?

A medical benefit allowance of up to $300.00 per covered member/employee's family is provided once every calendar year to cover unreimbursed medical expenses. Once you have incurred $300.00 in unreimbursed medical expenses in a calendar year, thereafter, the Fund will reimburse 1% per $1.00 per each additional unreimbursed medical expenses incurred during the same calendar year. These claims must be submitted no later than March 1st of the calendar year following the year expenses were incurred.

Limitation

- Charges in excess of the above allowance are the responsibility of the member.
- Excluded are procedures that are not covered under your underlying health plan.
- If you are not employed by the district during the time that the benefit is offered (Jan 1st - March 1st), then you are ineligible for the benefit.
- New hires may only submit receipts from the time they were employed by the district.

How to Receive the Medical Benefit

Submit all claims for the prior calendar year to the address at the top of the Benefit Claim Form. You can apply for this benefit between January 1st and no later than March 1st. It is based on the tax year. When the year is over, print your latest Explanation of Benefits from the insurance company website or what you receive in the mail. For prescriptions, obtain a printout of copays from the pharmacy. The documents must state the date of service, patient's name and the amount paid. Keep copies of everything you send. If you do not hear anything in 30 days, we

encourage you to call D.H. Cook Associates or visit their website and register your account. If they did not receive your information, resubmit your claim. New hires are only able to submit claims/receipts from their Date of Hire through December 31st. Do not send in individual E.O.B.s for each visit/prescription.

HEARING AID BENEFIT

What Benefits are Paid?

This benefit provides up to $350.00 once every three years for every **covered member/employee only.** Once you have incurred $350.00 in out-of-pocket hearing aid expenses in a three year period, the member must submit a dated and itemized bill marked "paid" and Benefit Claim Form to the address at the top of the form. Proof of medical payment must accompany the paid bill showing your out-of-pocket expense.

LEGAL SERVICES PLAN

The Legal Services Plan is provided by NYSUT. It gives members access to attorneys who will answer legal questions, write letters, and review documents relating to personal legal matters. To access this benefit, call the National Legal Office of Feldman, Kramer & Monaco at (800)832-5182 or (631)231-1450.

RETIREMENT BENEFITS

Continuation of Benefits after Retirement or During Leave

When you retire or if you go on leave, you may keep your Benefit Plan coverage in effect, provided you maintain membership in the DFUT and make the necessary contributions to the DFUT Welfare Fund. During the month that your retirement or leave becomes effective, you will receive a letter from the Fund Office indicating the cost for maintaining the Fund Benefits on an individual basis. If you do not receive this letter, you must notify the Fund Office before the date of your retirement or leave, and the Fund Office will send you the necessary information before your retirement or leave begins. If you decide not to continue your coverage before the date of your retirement, you will not be eligible for benefits in the future. If you take a leave without continuing your dental plan benefits on an individual basis you may not be eligible for these benefits unless you return to full time teaching after your leave.

TERMINATION OF BENEFITS

Your Fund benefits and your dependent's Fund benefits will stop on the earliest of the following dates:

- When you are no longer eligible
- When there is a non payment of premiums
- Your dependent's insurance will also terminate when he or she is no longer an eligible dependent.