WAPPINGERS

CONGRESS

of

TEACHERS

WELFARE

TRUST

FUND

September 2019
WAPPINGERS CONGRESS OF TEACHERS
WELFARE TRUST FUND

280 New Hackensack Road Wappingers Falls, New York 12590
845-227-5065

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HIGHLIGHTS OF YOUR BENEFITS

GENERAL INFORMATION
Are You Eligible For Coverage Under This Fund?
Are Your Dependents Eligible For Coverage Under This Fund?
When Does Your Eligibility For Coverage End?
When Does Coverage End For Your Dependents?
Continuation of Coverage – Statutory
COBRA Continuation Coverage
Continuation Under the Family & Medical Leave Act (FMLA)
Non-Statutory Retirement
What Is Coordination of Benefits And How Does It Work?
Special Coordination of Benefits
Claims Information
Amendment or Termination of Benefits
Third-Party Reimbursement/Subrogation
Right to Recoup Benefit Payments Made In Error or To Suspend Benefits Coverage

Benefits Payable On Behalf of A Deceased Member
Notice of Privacy Practices

DENTAL BENEFITS
Preauthorization
Dental Maximums
Participating Provider Option
Exclusions

HEARING AID BENEFIT
Who is Eligible for the Benefit?
What is the Benefit?
What is not Covered?
How to Obtain the Benefit

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
Life Insurance Benefits
How do I obtain Benefits?
Designation of Beneficiary
Disability Clause
Conversion Privilege Feature
Accidental Death and Dismemberment Insurance
AD & D Schedule
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>COINSURANCE/COPAY REIMBURSEMENT</td>
<td>24</td>
</tr>
<tr>
<td>Who is Eligible?</td>
<td>24</td>
</tr>
<tr>
<td>What is the Benefit?</td>
<td>24</td>
</tr>
<tr>
<td>How to File a Claim</td>
<td>24</td>
</tr>
<tr>
<td>When to File a Claim</td>
<td>24</td>
</tr>
<tr>
<td>PRESCRIPTION CO-PAYMENT REIMBURSEMENT</td>
<td>25</td>
</tr>
<tr>
<td>Who is Eligible?</td>
<td>25</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>25</td>
</tr>
<tr>
<td>When and how to file a claim</td>
<td>25</td>
</tr>
<tr>
<td>OPTICAL BENEFITS</td>
<td>25</td>
</tr>
<tr>
<td>Plan Benefits</td>
<td>26</td>
</tr>
<tr>
<td>Network Doctor Info</td>
<td>26</td>
</tr>
<tr>
<td>Eyewear Selection</td>
<td>27</td>
</tr>
<tr>
<td>Costs for services</td>
<td>27</td>
</tr>
<tr>
<td>Lenses/Coating Inclusion</td>
<td>27</td>
</tr>
<tr>
<td>Special Features</td>
<td>28</td>
</tr>
<tr>
<td>Out-of-Network Provider Benefits</td>
<td>29</td>
</tr>
<tr>
<td>Exclusions</td>
<td>29</td>
</tr>
<tr>
<td>Contact Lense Replacement</td>
<td>30</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>31</td>
</tr>
<tr>
<td>FINANCIAL COUNSELING PROGRAM</td>
<td>32</td>
</tr>
<tr>
<td>GROUP LEGAL SERVICES PLAN</td>
<td>33</td>
</tr>
<tr>
<td>Who is Eligible?</td>
<td>34</td>
</tr>
<tr>
<td>General Rules Regarding Coverage</td>
<td>34</td>
</tr>
<tr>
<td>Appeals to the Board of Trustees</td>
<td>34</td>
</tr>
<tr>
<td>How To Use The Legal Services Program</td>
<td>34</td>
</tr>
<tr>
<td>Representation In Civil Matters</td>
<td>35</td>
</tr>
<tr>
<td>Legal Defense Benefit</td>
<td>35</td>
</tr>
<tr>
<td>Uncontested Legal Separation Benefit</td>
<td>37</td>
</tr>
<tr>
<td>Uncontested Divorce Benefit</td>
<td>38</td>
</tr>
<tr>
<td>Uncontested Annulment Benefit</td>
<td>39</td>
</tr>
<tr>
<td>Adoption Benefit</td>
<td>39</td>
</tr>
<tr>
<td>Personal Bankruptcy Benefit</td>
<td>40</td>
</tr>
<tr>
<td>Change of Name Benefit</td>
<td>41</td>
</tr>
<tr>
<td>Homeowner's Rights Benefit</td>
<td>41</td>
</tr>
<tr>
<td>General Legal Matters</td>
<td>42</td>
</tr>
<tr>
<td>General Consultation Benefit</td>
<td>43</td>
</tr>
<tr>
<td>Document Review Benefit</td>
<td>43</td>
</tr>
<tr>
<td>Will Benefit</td>
<td>44</td>
</tr>
<tr>
<td>Personal Injury Benefit</td>
<td>44</td>
</tr>
<tr>
<td>Arraignment Assistance - Telephone Consultation Benefit</td>
<td>45</td>
</tr>
</tbody>
</table>
Consumer Protection Benefit........................................................................................................46
Identity Theft Protection Benefit ..................................................................................................46
Living Will/Health Care Proxy Benefit .........................................................................................47
Appointment of Agent to Control Disposition of Remains Benefit ............................................48
Planning for the Elderly Benefit ....................................................................................................48
Estates and Administration Benefit .............................................................................................49
Estate Planning Benefit .................................................................................................................49
Designation of Person in Parental Relation Benefit ......................................................................50
Counseling of Unemancipated Children Benefit ..........................................................................51

GENERAL EXCLUSIONS........................................................................................................51
Highlights Of Your Benefits

This section of your booklet provides the highlights of benefits provided by the Wappingers Congress of Teachers Welfare Trust Fund. All of the benefits are described in detail in the appropriate sections later in the booklet.

DENTAL BENEFIT

Eligibility: Members, Spouses, and Dependents

Options: Comprehensive Dental Expense Benefits self-insured by the Fund.

Deductible: None

<table>
<thead>
<tr>
<th>Maximums</th>
<th>Member</th>
<th>Spouse</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental (Annual)</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Dental Panel: Yes

ORTHODONTICS

Eligibility: Eligible dependents up to their 19th birthday

Benefit: Work-Up $100

Initial Appliance $750

Active Treatments $75 (24 consecutive months)

VISION CARE

Eligibility: Members and Dependents, once every 12 months.

Benefit: Eye exam and Eyeglasses, or Contact lenses.

Options: Davis Vision listing of participating providers or any out-of-network provider.

Allowance: $90 for non-plan frames

$150 for non-plan contact lenses
HEARING AID

Eligibility: Member, Spouse, Dependent children

Benefit: $750 per ear every 48 months and an additional $50 during the same period

COINSURANCE/CO-PAYMENT REIMBURSEMENT

Eligibility: Member and/or Dependents

Benefit: $300 annual family maximum and 1% of all additional coinsurance/copayment costs

PRESCRIPTION CO-PAYMENT REIMBURSEMENT

Eligibility: Member and/or Dependent(s)

Benefit: $200 annual family maximum and $5.00 per additional prescription

**Retirees covered under the basic plan are not covered for the prescription benefit.**

LIFE INSURANCE

Eligibility: Member, Spouse, Dependent children

Benefit: Member: $30,000
Spouse: $5,000
Dependent Child: $1,000

LEGAL SERVICES PLAN

Eligibility: Member only unless otherwise specified.

Benefit: A comprehensive legal services benefit plan, which stresses the "preventive medicine" approach to provide accessibility to counsel by all members. Some benefits include: wills, real estate closings, estate planning, powers of attorney and consumer protection, and the “designation of person in parental relation” benefit.

FINANCIAL COUNSELING PROGRAM

Eligibility: Active and Eligible Retired Members.

Benefit: A program providing a personal review of your finances and to help answer your financial questions.
GENERAL INFORMATION

This section of your booklet provides you with general information that applies to all benefits available through the WCT Welfare Trust Fund, including:

- whether you are eligible and, if so, when your eligibility starts,
- which of your dependents can be covered for benefits and when their coverage becomes effective, and
- how you can continue your benefits during certain times when you would normally lose them.

ARE YOU ELIGIBLE FOR COVERAGE UNDER THIS FUND?

You are eligible for coverage if you are an eligible member defined as follows.

1. Individuals in the bargaining unit represented by the Wappingers Congress of Teachers (“WCT”) employed full time for whom contributions are made by the District to the Fund; and

2. Individuals in the bargaining units represented by the Wappingers Congress of Administrators (“WAA”), Wappingers Registered Professional Nurses Association (“WRPNA”), Supervisory, Technical, Executives and Professional Staff Association (“STEPSA”) and Wappingers Central School District Office Unit (“WCSDOU”) employed full time and for whom contributions are made by the District to the Fund pursuant to participation agreements with the Fund.

3. Individuals in the bargaining unit represented by the WCT working part-time for a minimum of 17.5 hours per week, subject to their payment of the applicable self-pay contributions set by the Fund.

4. Any employees of the District in other bargaining units and non-bargaining units, whom the Trustees may determine in their sole discretion, are eligible to participate in the Fund.

How do you enroll?

You enroll for coverage by completing an "enrollment" form provided by the Trust Fund. If you wish to cover any eligible dependents, you must elect coverage for all of your eligible dependents. If you do not have any eligible dependents when you enroll, you may apply for dependent coverage when you acquire an eligible dependent. Applicable documentation establishing status of eligible dependents (e.g. birth certificate, marriage certificate, etc. must be provided with your enrollment form.)
When Does Your Eligibility Begin?

You are eligible for the benefits described in this booklet after you complete one day of active employment, provided you have enrolled for coverage as described in the previous section.

- If you enroll between the first and fifteen day of the month, your eligibility for benefits begins on the first day of that month.
- If you enroll between the sixteenth day and last day of the month, your eligibility for benefits begins on the first day of the following month.

The member must be actively at work at the District's regular place of business, and physically able to perform all such duties.

Work or duties performed at home or while confined in a hospital or other medical institution may not be used to meet this requirement.

ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE UNDER THIS FUND?

Your eligible dependents will receive certain benefits from the Fund. Your eligible dependents include:

- your spouse to whom you are legally married,
- your unmarried dependent children are covered to the end of the month in which they turn 26 (for example, the child turns 26 on July 1st, his/her last day of coverage will be July 31st),

Your unmarried children over age 26 who are unable to do any work to support themselves because of physical handicap or mental illness, developmental disability or mental retardation. The incapacity must have started before the child reached age 26, must be certified by a doctor, and may have to be recertified periodically. You must submit written proof of the disability to the Fund Office. Coverage under this provision will end if the dependent child marries, becomes eligible for Medicare, or becomes able to earn a living.

*Dependent children* are your natural children, stepchildren, legally adopted children, including children in a waiting period prior to finalization of adoption, and any other children related to you by blood or marriage who are living in a regular parent-child relationship with you and are dependent upon you for financial support and maintenance.

If your dependent is eligible for benefits as a member, then he or she is only eligible for member benefits and not for benefits as your dependent.
When Are Your Dependents Eligible for Coverage?

Your dependents are eligible for coverage when you become eligible for coverage. If you acquire a new dependent after you become covered, they will become covered on the day they became eligible dependents.

When Does Your Eligibility for Coverage End?

Your eligibility for coverage under the benefits described in this booklet will end when the first of these events occurs:

• you are no longer eligible for coverage (see page 3),
• the Fund no longer provides benefits for your class of employee,
• contributions made on your behalf stop, or
• the last day of the month after:
  • your employment with a contributing employer stops,
  • you enter military service,
  • your employer is no longer a contributing employer,
  • you work less than the required hours for eligibility

When Does Coverage End for Your Dependents?

Coverage under the Fund for your dependents will end when the first of these events occurs:

• your coverage ends,
• your dependent is no longer considered an eligible dependent as defined on page 4,
• your dependent enters the Military Services,
• your death, or
• the Fund no longer provides coverage for any dependents.
Under certain circumstances when coverage for your dependents would otherwise end, they may be eligible to continue their coverage under the Fund or, for those benefits provided by an insurance carrier, convert to an individual policy directly with the carrier.

CONTINUATION COVERAGE

1. STATUTORY

COBRA CONTINUATION OF COVERAGE

Federal law requires that most group health plans, including the plan of the Wappingers Congress of Teachers Welfare Trust Fund, (the “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, 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 who 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, vision, prescription drug co-pay reimbursement, hearing aid and co-insurance/co-payment reimbursement benefits.**

The following language required by the federal health care law. The Fund cannot represent whether or not dental, vision and other supplemental benefits are 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 the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
How long will continuation coverage last?

In the case of a loss of Fund coverage due to end of employment or reduction in hours of employment with the District, coverage generally may be continued only for up 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, 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 District, 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 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 who 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 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 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 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 first qualifying event had not occurred. You must notify the Fund 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, you must complete the Fund’s Continuation Coverage Election Form and furnish it according to the directions 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 plans imposing preexisting condition exclusions; however, such exclusions 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.

For more information

If you have any questions concerning COBRA continuation coverage, you should contact the Fund Administrator at (845) 227-5065.

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.)

Keep Your Plan Informed of Address Changes

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

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). If you take a FMLA leave, your employer must continue to contribute to the Fund on your behalf and certain health-related benefits through the Fund must continue. However, if you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid toward your coverage during your leave unless you do not return because of a serious health condition of yourself or a family member or other circumstances beyond your control.

If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation coverage.

Contact the Fund Administrator for more information about your rights and your dependents' rights to continuation coverage.

2. NON-STATUTORY

RETIREMENT

The Fund offers eligible members who retire, the option to purchase retiree benefits for them and their eligible dependents.

In order to be eligible to participate in retiree continuation coverage, the retiree must have maintained active membership in the Wappingers Congress of Teachers (“WCT”), the Wappingers Administrators Association (“WAA”), the Supervisory, Technical, Executive and
Professional Staff Association ("STEPSA"), The Union for the Wappingers Central School District Office Unit of the Duchess County Educational Local 867 ("WCDOU") or the Wappingers Registered Professional Nurses Association ("WRPNA"), as defined by those respective bodies, for the ten consecutive years preceding retirement.

At the time of retirement, you must be an active member in good standing of the WCT, WAA, SETPSA, WCDOU or WRPNA, and thereafter must maintain membership in the WCT, WAA, SETPSA, WCDOU or WRPNA, as the case may be, and pay the required union dues.

**Initial Enrollment**

As soon as the Fund is notified by the District of your retirement, you will receive a retiree benefits enrollment package, including an enrollment form and letter advising of the cost to purchase retiree benefits.

You **must** enroll in retiree benefits at the time of your retirement and continue to pay the applicable self-pay contributions set by the Fund, in order to remain eligible. **If you do not enroll at the time of your retirement, you will not be permitted to enroll in the future. If you do not pay the applicable self-pay contributions set by the Fund for any period of coverage, retiree benefits will be immediately terminated and you will not be permitted to re-enroll in the future.**

**Benefit Plan Options**

At the time of your initial enrollment, you must elect to purchase one of the following three plans for yourself (and your eligible dependents, if desired):

1. **Basic Plan** – dental, vision, hearing aid benefits.
2. **Enhanced Plan** – dental, vision, hearing aid prescription drug co-payment reimbursement and coinsurance/copayment reimbursement benefits.
3. **Enhanced Plus Plan** – dental vision, hearing aid, prescription co-payment reimbursement, coinsurance/copayment reimbursement, legal services and financial counseling benefits.

The benefits provided under these plans are the same provided to active Fund members, as described in the Fund’s comprehensive benefits booklet.

The self-pay contribution rates to participate in these plans are set by the Fund’s Board of Trustees and are subject to review and revision on an annual basis. The current rates for individual and family coverage will be provided in your initial enrollment package and are available from the Fund office. **If you do not pay the applicable self-pay contributions set by the Fund for any period of coverage, retiree benefits will be immediately terminated and you will not be permitted to re-enroll in the future.**
Individual or Family Coverage

At the time of your initial enrollment in one of the Fund’s retiree plans, you must select either individual or family coverage and pay the applicable premium rate.

If you do not enroll your eligible dependents in family coverage at the time of your initial enrollment, you will not be permitted to do so in the future. **You may however enroll a newly acquired dependent (e.g. new spouse, new natural, adopted or step-child, etc.)**

Annual Re-Enrollment

After your initial enrollment, each year you will receive an annual re-enrollment notice.

During the annual re-enrollment period, you may change from a lesser plan to a richer plan (e.g. from basic to enhanced) or from a richer plan to lesser plan (e.g. from enhanced to basic).

During the annual re-enrollment period, you may also change from family coverage to individual coverage, but **you may not change from individual coverage to family coverage, unless to add a newly acquired dependent, as previously discussed.**

After re-enrollment, if you do not pay the applicable self-pay premium set by the Fund for any period of coverage, retiree benefits will be immediately terminated and you will not be permitted to re-enroll in the future.

Continuation of Life Insurance

Retirees may also elect to continue their Fund life insurance benefits provided they pay the applicable premiums. You will receive a separate letter from the Fund with your initial retiree benefits enrollment package advising how to continue life insurance benefits and the applicable cost.

WHAT IS COORDINATION OF BENEFITS AND HOW DOES IT WORK?

When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all Group Plans will not exceed 100% of the total amounts charged.

Claim Procedures Under the Coordination of Benefits Provision

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

- Submit your claim to the Daniel H. Cook Associates, Inc. first.
- After you have received payment from the Fund, you may submit a claim for the unpaid balance 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.

• The total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of the total amount charged.

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

• Your spouse must submit a claim to his or her plan first.

• After the claim is paid by your spouse's plan, a claim for the unpaid balance may be submitted to this Fund along with an explanation of benefits received from the other plan.

• Any additional benefits, which may be due for this claim, will be paid by this Fund according to plan limitations.

• The total amount paid for each claim from any group plan under which your spouse is eligible and from this Fund cannot exceed 100% of the total amount charged.

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

• Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in a calendar year.

After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan.

The payment you receive for each claim from both plans cannot exceed 100% of the total amount charged.

If the claim is submitted for a child whose parents are divorced when one parent is a covered member of this Fund and the other parent is a covered member of another plan:

If the parent with custody has not remarried,

• submit the claim to the plan which covers the parent with custody first.

• after the claim has been paid by the first plan then it may be submitted to the second plan with an explanation of benefits received from the first plan.

If the parent with custody has remarried,

• submit the claim to the plan which covers the parent with custody first.
• submit the claim to the plan which covers the stepparent second.

• submit the claim to the plan which covers the parent without custody last.

If there is a court order, which establishes financial responsibility for the medical, dental or other health care expenses of the child, submit the claim to the plan which covers the parent with the court ordered responsibility first. A copy of such court order must be submitted with your claim.

SPECIAL COORDINATION OF BENEFITS

Members and their spouses who are also Fund members and their covered children, can receive dental and hearing aid benefits under each other’s coverage. In other words, spouses who are both Fund members may be covered as dependents under each member’s coverage and their children may be covered as dependents under both member-parents’ coverage. This is known as “Special Coordination of Benefits” (SCOB).

SCOB applies as follows:

**Dental Benefits**

If you (or your children) utilize the services of a non-participating dentist whose charges are above the set amounts reimbursed under the Fund’s schedule of dental benefits, you will be eligible for additional reimbursement under your spouse’s Fund dental coverage, subject to the Fund’s applicable annual maximum dental benefit allowances.

**Example:**

$500 = Dentist’s actual charges for a covered procedure  
$300 = Set amount covered by Fund for the procedure  
$500 = Total amount Fund would pay under SCOB  
($300 under member/patient’s coverage)  
($200 under member-spouse coverage)

If you utilize the services of a panel dentist, you would generally have no out-of-pocket costs. If there are any co-payments, they will be paid by the Fund under your spouse’s coverage through SCOB.

SCOB does **not** extend limitations on time or frequency of treatment. For example, one (1) exam every six (6) months does not become one exam every three (3) months.

Under SCOB the annual dental maximum allowances will be up $4,000 per year for each covered family member.

To obtain special coordinated dental benefits, check the box indicating so on the top of the Fund’s dental claim form.
Hearing Aid Benefits

Each covered family member is eligible for reimbursement of up to $1,500 ($750 under each Fund member’s coverage) per ear every 48 months to be used for the purchase of a hearing aid. Payment to the member may not exceed the actual charges for the hearing aid service.

Example:  
$1,000 = Provider’s charge for hearing aid  
$750 = Set amount covered by Fund for the service  
$1,000 = Total amount Fund would pay under SCOB  
($750 under member/patient’s coverage)  
($250 under member-spouse/domestic partner’s coverage)

To obtain special coordinated hearing aid benefits, check the box indicating so on the top of the Fund’s hearing aid claim form.

CLAIMS INFORMATION

Filing Claims

You must file claims to receive your WCT Welfare Trust Fund benefits. Claim forms are available from the Fund Office or the main office of each school. All claims should be sent to the Fund Office at Daniel H. Cook Associates, Inc., 253 West 35th Street, 12th Fl., New York, NY 10001.

Appeal Procedure

The benefits provided by this Fund may be changed by the Board of Trustees. 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 operations.

All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject to review only by the Board of Trustees. A covered member, eligible dependent or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees, WCT Welfare Trust Fund, 280 New Hackensack Road Wappingers Falls, New York 12590. 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.

In Addition

When any change occurs in your status marriage, divorce, separation, birth or adoption of a child, death of an eligible dependent or you wish to change the beneficiary of your Life Insurance/AD&D, please notify the Fund Office. It is important, and to your advantage, that you keep the Fund Office up-to-date on your current status.
AMENDMENT OR TERMINATION OF BENEFITS

The benefits provided by this Fund may, from time to time, be changed, modified, augmented, or discontinued by the Board of Trustees. 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 the Fund and governs its operations.

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

- When the Fund is terminated;
- When you are no longer eligible;
- When there is a non-payment of any required self-pay member contributions / payments;
- When the Employer ceases to make contributions on your behalf to the Fund; or
- Your dependents' coverage will also terminate when they are no longer your eligible dependents.

Active and retired benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits either before or after his or her retirement. The Trustees may expand, modify or cancel the benefits for active and retired members; change eligibility requirements or the amount of the direct payments; and otherwise exercise their prudent discretion at any time without legal right or recourse by an active or retired member or any other person.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through 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:

a. To reimburse the Fund, to the extent of benefits paid by it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise;
b. 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 in 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; and

c. 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.

**RIGHT TO RECOUP BENEFIT PAYMENTS MADE IN ERROR OR TO SUSPEND BENEFITS COVERAGE**

The Fund has the right to recoup overpayments that were caused by an error in the processing of a claim, or, if additional information comes to the attention of the Fund after the claim has been paid. Furthermore, the Fund has the right to suspend one or more benefits if you have received overpayments or have in any way abused the Fund’s benefit program.

If the Fund finds it has overpaid you, or an otherwise ineligible dependent, for a particular benefit, it has the right to recoup the excess amount from you. The Fund may bill you for overpayments made, and/or, it may also reduce future benefit payments to offset the overpaid amounts or it may suspend your benefits until the overpayment is recouped. Such offset and/or suspension will be applied to the member’s and eligible dependent’s benefits. An overpayment includes, but is not limited to, any payment made on claims submitted by individuals who are no longer eligible dependents (e.g. a divorced spouse of a member who did not elect to continue coverage under COBRA) as well as payment of the wrong amount on a claim.

**BENEFITS PAYABLE ON BEHALF OF A DECEASED MEMBER**

With respect to any benefits payable to a deceased member upon the date of death, or with respect to death benefits payable by virtue of the death of the member where the member’s designated beneficiary (of his/her life insurance benefit) has predeceased the member and a successor has not been designated, or where the member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered member’s:

A. Surviving spouse;

B. If no surviving spouse, to the surviving children equally, or

C. If no surviving children, to the covered member’s estate.
NOTICE OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the Fund to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund’s privacy notice, which was previously distributed to all members and is distributed to all new members upon enrollment, a copy of which is available from the Fund’s Third-Party Administrator, Preferred Group Plans, Inc.

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 the Fund’s privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

DENTAL BENEFITS
COMPREHENSIVE DENTAL EXPENSE BENEFITS

The WCT Welfare Trust Fund provides Comprehensive Dental Expense Benefits. This benefit is self-insured and is administered by a third-party administrator.

Comprehensive Dental Expense Benefits are provided for you and your eligible dependents.

Actively employed members may decline coverage of Fund dental benefits for themselves and/or any enrolled dependents at any time by completing a Declination of Coverage form, which can be obtained by contacting the Fund office.

Since Fund benefits for actively employed members are funded by collectively bargained employer contributions, you will not receive a rebate, reimbursement or any compensation if you decline dental benefits.

What are covered expenses?

Covered expenses are charges for a broad range of dental services. For most services the amount counted as a Covered Expense is determined from a schedule of Covered Dental Services which is available from the Fund Office.

What is the Deductible?

THERE IS NO DEDUCTIBLE.
How does comprehensive dental expense Benefit Work?

Comprehensive Dental Expense Benefits provide scheduled reimbursement for expenses you have for preventive, basic and major non-orthodontic dental services with no deductible requirement.

The Schedule Of Benefits

Your Comprehensive Dental Expense Benefits program pays a set amount for covered expenses you incur for preventive, basic and major dental services up to a maximum benefit of $2,000 per year for each covered member and $2,000 per year for each spouse and eligible dependent. There is no annual deductible for you or your dependents. The maximum amounts the Plan will pay for specific services are set forth in the Fund’s schedule of dental benefits, which is available from the Fund office.

Pre-Authorization

Pre-authorization is not required, however, benefits should be determined before you begin treatment if the charges for the treatment will be more than $400. You should ask your dentist to describe the proposed treatment and charges on a Dental Claim Form. The form should then be sent to Daniel H. Cook Associates, Inc. whose address appears on the top portion of the claim form. We will notify you and your dentist how much we will consider as Covered Expenses and how much we will pay. It is to your advantage to know exactly what you will be paid before treatment begins.

Alternate Benefit Provisions

When more than one dental service would provide suitable treatment, your benefits will be based on the treatment determined by the Plan to be best suited to your condition by accepted standards of dental practice. If two services would each provide satisfactory results according to accepted standards of dental practice and one service is less expensive than the other, the Plan will reimburse up to the maximum allowance for the less expensive treatment.

DENTAL BENEFIT MAXIMUMS

<table>
<thead>
<tr>
<th></th>
<th>Member</th>
<th>Spouse</th>
<th>Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental (Annual)</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**ALL PROSTHETIC SERVICES ARE PAYABLE ONCE PER FIVE YEARS**

All lifetime maximums are subject to the Annual Dental Maximum. The annual dental maximum is a calendar year maximum.
PARTICIPATING PROVIDER OPTIONS

On behalf of the WCT Welfare Trust Fund, its third-party administrator, Daniel H. Cook Associates, Inc., has contracted with certain dentists to provide basic dentistry for covered services at no out-of-pocket expense for members and co-payments for dependents. A listing of the dentists, fee schedule, and the co-payments are available from the Fund office. These dentists have agreed to provide covered dental procedures and accept the Fund’s dental fee schedule as payment in full for covered services, at no out-of-pocket expense to Fund members. This listing is provided as an information service only, for the convenience of covered members. The Fund does not recommend the services of any particular dentist. Participating providers are selected solely upon their agreement to accept the Fund’s dental fee schedule as payment in full for covered services. If you are charged for a covered service by a panel provider, please do not pay and contact the Fund Office immediately. The Fund office requests that you report any irregularities to the Dental Consultant’s Office at (212) 505-5050.

The Fund’s list of participating dentists is provided as an informational service only, for the convenience of covered members and their eligible dependents. The Fund does not recommend the services of any particular dentist. The Fund makes no representation as to the quality of services provided by any dental provider. Each Fund member and eligible dependent is responsible for making his/her own decision about the use of dental providers.

ORTHODONTIC BENEFITS

Orthodontic services are reimbursed according to a fee schedule up to a lifetime maximum of $1,800.00 per eligible dependent child up to their 19th birthday. A period of orthodontic treatment starts on the first day you incur a covered expense for your dependent child for orthodontia and extends for a period of 24 consecutive months or less if the treatment is completed in less time. The orthodontic benefit is not included in the yearly dental maximum.

What are Your Orthodontic Benefits?

- Up to $100 for the initial work-up. Once per eligible dependent child per lifetime.
- Diagnosis and insertion of the initial appliance: Once, up to $750.00, per eligible dependent child per lifetime.
- Up to $75 per active monthly visit with a lifetime maximum of 24 consecutive visits. If your dependent misses a monthly visit, the Fund will not reimburse for that month but it will be counted toward the 24 consecutive month’s maximum.
- You will be responsible for any out of pocket expenses incurred above what the fund provides.

Please note that the initial work-up and the initial appliance are reimbursed only once during a period of orthodontic treatment.

Note: You will be responsible for any out-of-pocket expenses incurred in excess of the benefits the Fund provides.
EXCLUSIONS

Benefits will not be paid for charges for:

- treatment from anyone other than a licensed dentist or physician, except routine cleaning of teeth and fluoride application which is performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician,

- facings, veneers, or similar material placed on molar crowns or pontics,

- services performed by a member of your or your spouse's family,

- services or supplies that are cosmetic in nature or directed toward a cosmetic end,

- any service or supplies incurred, installed, or delivered before you or your dependents become eligible for benefits under this Plan,

- replacing a lost, missing or stolen prosthetic appliance,

- a broken appointment,

- any services received from a medical department, clinic or any facility provided or furnished by your or your dependent's employer,

- any service that is not necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist,

- services or supplies that do not meet accepted standards of dental practice including experimental services or supplies,

- services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared,

- any duplicate prosthetic appliance except as specifically provided,

- completing claim forms,

- oral hygiene, or dietary instruction or plaque control programs,

- implants and implant services,

- wiring or bonding teeth or crowns to act as a splint for any reason,
• an injury arising from employment,
• illness covered by Workers' Compensation,
• services or supplies for which you are not required to pay,
• expenses incurred outside of the United States or Canada unless you or your dependents are residents of one or the other and the charges are incurred while traveling on business or for pleasure,
• appliances, restorations, or any procedure to alter vertical dimension or restore occlusion,
• services or supplies not specifically listed under covered expenses.

Extension Of Dental Benefits

If your dental coverage terminates, benefits will be extended for expenses you have for dentures, fixed bridgework, crowns and inlays, or endodontic treatment, including root canal therapy, if:

• treatment was begun before coverage ended,

• appliances, where appropriate, were ordered before coverage ended, and treatment is completed within 60 days after the date your ended.

HEARING AID BENEFIT

Who is eligible......All covered members, their spouses and dependents are entitled to this benefit.

What is the Benefit....This benefit provides for a $750 benefit per ear every 48 months to be used for the purchase of a hearing aid device. Once you have received the initial $750 benefit per ear, the Fund will provide an additional benefit of $50 to be used for the purchase of additional hearing aids for that same 48-month period.

What is not covered.....The benefit does not provide for the purchase of hearing aid batteries or repairs.

How to Obtain the Benefit.....To obtain the Hearing aid benefit, simply contact the Fund office and request a hearing aid claim form.

Claims must be submitted within one year of date of service.
LIFE INSURANCE and ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

The Wappingers Congress of Teachers Welfare Trust Fund provides you with group life and accidental death and dismemberment (“AD&D”) insurance benefits at no cost to you. These benefits are provided through a policy of insurance, which is underwritten by an insurance carrier. These benefits are for you, the active member, your spouse and for your eligible dependent children (the “insureds”).

The following is a brief description of your group Life and AD&D insurance benefits. For a complete, detailed explanation of these benefits, please refer to your Certificate of Coverage.

What Is Your Life Insurance Benefit?

When the insurance company receives proof of the death of an insured member or dependent under the policy, the following amounts will be paid to the designated beneficiary:

- death of the member, in the amount of $30,000.00
- death of the member’s spouse, in the amount of $5,000.00
- death of the member’s eligible dependent child, in the amount of $1,000.00.

Retirement (With respect to Life Insurance only)

The life insurance benefit only is extended to eligible retirees, who continue to pay the applicable annual premium directly to the Fund (see page 9 continuation coverage upon retirement).

Note: Retired members are not eligible to continue AD&D benefits

Retired members are eligible for the following life insurance benefit amounts:

- Retired Members less than age 70 -$30,000
- With respect to Retired Members over age 70 and over - $5,000

How Benefits Are Obtained?

1. A member of the family of the deceased or the beneficiary of the life insurance benefit notifies the Fund Office of the death of the member.

2. The Fund office notifies the Life Insurance Company, which will send forms to the Beneficiary.

3. The beneficiary, or his/her authorized representative, completes the forms required by the life insurance company and sends them to the Life Insurance Company.
4. The Life Insurance Company will process the claim.

**Designation of the Beneficiary**

The beneficiary is designated on the appropriate form provided by the life insurance company, available at the Fund Office.

It is important that the designation of 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. These forms may be obtained upon request from the Fund Office.

Should the last-named beneficiary predecease the member, or should no beneficiary be named, instead of making payment to the appropriate estate, the insurance company has the right to make payment to the first surviving family members in the order listed below:
- spouse;
- child or children equally;
- parents equally; or
- sisters or brothers equally.

**What Happens To Your Life Insurance If You Become Disabled?**

Your life insurance benefit will continue after the date your insurance would otherwise have ended if you become disabled before you reach age 60. Coverage will continue with no premium requirement as long as you remain disabled and provide the required proof of disability to the insurance carrier within three months after your life insurance would otherwise end and as frequently as may be reasonably requested by the insurance company thereafter. You must also notify the Fund Office of your disability. Failure to do so may jeopardize your future benefits.

**Conversion Privilege Feature**

If your life insurance benefits under the Plan end because you are no longer a covered member, you terminate your employment, a disability ends or you do not provide the required proof of disability, you may convert to an individual life insurance policy at your own expense directly with the insurer. To do so, you must submit a completed application and your first premium payment to the insurer within 31 days after the date your employment terminates or you or your dependents are no longer eligible to participate in the coverage of the plan.

**Accidental Death and Dismemberment Benefit**

The life insurance company will pay a benefit based on the life insurance benefit if, while you are insured under the policy, you sustain bodily injuries:

1. That result directly from an accident and independently of all other causes;
2. That, within 90 days of the date of the accident, result in one of the losses listed below; and

3. That are not excluded in the "Restrictions" section below.

**Loss and Benefit Schedule**

<table>
<thead>
<tr>
<th>Loss Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>For loss of life:</td>
<td>The Principal Sum</td>
</tr>
<tr>
<td>For permanent loss of one hand by severance at or above the wrist:</td>
<td>½ the Principal Sum</td>
</tr>
<tr>
<td>For permanent loss of one foot by severance at or above the ankle joint:</td>
<td>½ the Principal Sum</td>
</tr>
<tr>
<td>For the loss of the sight of one eye entirely, irrecoverably, and uncorrectable:</td>
<td>½ the Principal Sum</td>
</tr>
<tr>
<td>For two or more of the above losses in any one accident:</td>
<td>The Principal Sum</td>
</tr>
</tbody>
</table>

The insurance company will not pay more than the Principal Sum, regardless of the number of losses in any one accident.

**COINSURANCE/COPAY REIMBURSEMENT**

**Who is eligible…..** Member claiming for self and eligible participating dependents who participate in the Empire Healthy Advantage PPO and EPO Select 20 Plans provided by the Dutchess Educational Health Insurance Consortium (“DEHIC”).

**What is the Benefit…..** The Fund will reimburse up to $300 per covered family per calendar year for any in-network coinsurance and/or co-payment costs incurred under the DEHIC Empire Blue Cross Blue Shield Healthy Advantage PPO and EPO Select 20 Plans. Once the $300 is reached, the Fund will reimburse 1% of all additional in-network coinsurance and/or co-payment costs incurred during the same period.

**How to File a Claim…..** Obtain a coinsurance and/or co-payment reimbursement benefit claim form from the Fund office or the WCT website – [www.wcteachers.org](http://www.wcteachers.org). You must attach a claim summary from Empire Blue Cross Blue Shield verifying your coinsurance and/or co-payment expenses for the claim period. All claim forms must contain a total dollar amount at the bottom otherwise it will be returned to you without payment.

**When to File a Claim…..** Your claim must be submitted during the first quarter of the calendar
year following the calendar year during which your coinsurance and/or co-payment expenses were incurred. (Example: Coinsurance and/or co-payment expenses incurred between January 1, 2019 and December 31, 2019 must be claimed between January 1, 2020 and March 31, 2020).

**PRESCRIPTION CO-PAYMENT REIMBURSEMENT**

**Who is eligible**......Member claiming for self and eligible participating dependents.

**What is the Benefit**....Once annually, up to a maximum of $200, the Fund reimburses the member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Once the $200 maximum is reached, the Fund will provide an additional reimbursement of $5.00 per prescription. Prescriptions must be dispensed by a licensed pharmacist. Prescription services, which are covered are those eligible under your primary prescription plan.

**What is not covered**.....There is only one claim per family per calendar year. Individual prescriptions must be accompanied by a pharmacy printout or copy of receipt. Do not submit original receipts because the Fund is not responsible for loss if originals are submitted.

**How to File a Claim**.....Obtain a prescription co-payment reimbursement claim form from the Fund office. Pharmacy drug printouts may be attached to the claim form in lieu of filling out individual prescription lines proving that the patient’s name, date of purchase, prescription number, name of drug, prescription doctor’s name, dispensing pharmacy and the cost, or co-payment amount of the prescription to the patient is entered. The co-payment amount must be indicated either on the claim form or the pharmacy’s print-out. All claim forms MUST contain a total dollar amount of the bottom of the claim or it will be returned to you without payment. All items listed will be subject to verification.

**When to File a Claim** ...Your prescription drug claim MUST be submitted in the first quarter following the year charges were made in order to be eligible for coverage. (Example: Covered expenses incurred from 1/1/08 through 12/31/08 can be claimed between 1/1/09 and 3/31/09).

NOTE: The same rules and regulations governing your primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If for some reason you had to pay full price for a prescription, you MUST first submit the costs to your primary prescription plan prior to claiming. Do not submit your claim to the Fund unless all costs are backed by proof. Submissions at a later date will NOT be reconsidered for payment.

**OPTICAL BENEFITS**

The Wappingers Congress of Teachers Welfare Trust Fund provides a vision care plan administered by Davis Vision, Inc., a leading national administrator of routine Vision care
programs. Eligibility for vision care benefits is determined by the same rules that apply to your other Fund benefits.

Actively employed members may decline coverage of Fund optical benefits for themselves and/or any enrolled dependents at any time by completing a Declination of Coverage form, which can be obtained by contacting the Fund office.

**Since Fund benefits for actively employed members are funded by collectively bargained employer contributions, you will be receive a rebate, reimbursement or any compensation if you decline optical benefits.**

**What are the plan benefits?**

Every 12 months you and your eligible dependents are entitled to:

- A routine eye examination, including dilation as professionally indicated; and,
- A complete pair of eyeglasses; or,
- Contact lenses (in lieu of eyeglasses).

- $100 flat annual allowance for special contact lenses, not currently covered by the Fund, including but not limited to Gas Permeable lenses that correct astigmatism and Toric lenses. (Members only)

Coverage of special contact lenses used to treat a condition called Keratoconus. This benefit provides an in-network maximum allowance of $500.00 and an out-of-network maximum allowance of $250.00.

A Low Vision Benefit evaluation is provided every five (5) years with a $300.00 maximum charge for same; a low vision aid appliance allowance of $600.00 maximum per appliance and a lifetime maximum $1,200.00; a follow-up care allowance permitting four (4) visits in a five (5) year period at a maximum charge of $100 per visit.

**Who are the network doctors?**

They are licensed doctors who are extensively reviewed and credentialed by Davis Optical to ensure that stringent standards for quality service are maintained. Please call 1-800-999-5431 to access the Interactive Voice Response (IVR) Unit, which will provide you with the names and addresses of the network doctors near you.

**How do I receive services from a doctor in the network?**

- Call the network doctor of your choice and schedule an appointment.
• Identify yourself as a Wappingers Congress of Teachers Welfare Trust Fund member or dependent.

• Provide the office with the member's Social Security number and the date of birth of any dependent children needing services.

It's that easy! The doctor's office will verify your eligibility for services, and no claim forms are required!

**What types of eyewear may I select?**

• Any frame from the special Premier selection, (with equivalent retail values up to $175.00), displayed on the "Tower Collection" in most network doctor's offices.

• The fund will allow a $56.19 allowance toward the cost of non-covered frames.

• Any spectacle lens type; many are included at no additional cost.

• Contact lenses, in lieu of eyeglass lenses; standard, soft, daily-wear, disposable or planned replacement types are available for most prescriptions with a co-payment (see below).

**Please note:** Contact lenses can be worn by most people, but not by all. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglass lenses.

**What are my costs for services?**

• No co-payment is required toward your eye examination.

• No co-payment is required toward spectacle lenses.

• No co-payment is required toward a Premier frame from the "Tower Collection". A complete benefit (frame and lenses) from the “Tower Collection” could have comparable retail value in excess of $300.00.

• No co-payment will be required toward standard, soft, daily-wear, disposable* or planned replacement contact lenses in lieu of eyeglass lenses.

Your doctor will provide specific co-payment information for the type of lenses you require.

*New (to the doctor, or first-time) contact lens wearers will receive an initial supply (two multi-packs) of lenses, along with all necessary visits for proper fitting and recommended follow-up care. Existing contact lens wearers will receive four multi-packs of lenses.

**What lenses/coatings are included?**
The following optional lens types and coatings may be selected for no additional charge at a network doctor's office:

- Fashion Frame
- Designer Frame
- Premier Frame
- High Index Lenses.
- Polarized Lenses
- Polycarbonate Lenses
- Photochromatic Glass Lenses
- Blended Segment Lenses
- Scratch Resistant Coating
- Ultraviolet Coating
- Anti Reflective Coating - Standard
- Plastic Photosensitive Lenses
- Anti Reflective Coating – Premium
- Intermediate Vision Lenses
- Standard or premium brands of progressive addition multifocal lenses.**

**Progressive addition multifocals can be worn by most people, but not by all. Conventional bifocals will be supplied for anyone who is unable to adapt to progressive addition lenses.

*When will I receive my eyeglasses?*

Your eyeglasses will be sent to your doctor from the laboratory generally within two to five business days. Additional delivery time may be required when out-of-stock frames, glare resistant treatment, or specialized prescriptions or non-"Tower Collection" frames are selected.

*More special features:*

*Replacement Contact Lenses By Mail*
Free membership and access to Lens 1-2-3, a mail order replacement contact lens service providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-712);

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied by Davis Vision.

**What about out-of-network provider benefits?**

You may obtain services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a doctor who participates in the network.

If you choose an out-of-network provider, you must:

Pay the provider directly for all charges; and

Submit a claim for reimbursement to;

Vision Care Processing Unit
P.O. Box 2270
Schenectady, NY 12301

Services will be reimbursed up to the following; schedule of maximums:

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye examination</td>
<td>$30.00</td>
</tr>
<tr>
<td>Single vision lenses</td>
<td>$25.00 (per pair)</td>
</tr>
<tr>
<td>Bifocal lenses</td>
<td>$35.00 (per pair)</td>
</tr>
<tr>
<td>Trifocal lenses</td>
<td>$45.00 (per pair)</td>
</tr>
<tr>
<td>Lenticular lenses</td>
<td>$45.00 (per pair)</td>
</tr>
<tr>
<td>A frame</td>
<td>$30.00</td>
</tr>
<tr>
<td>Contact lenses</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

To request claim forms, please call 1-800-999-5431.

**May I use the benefit at different times?**

All services must be obtained at one time from a network or an out-of-network provider.

**Are there any exclusions?**

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
• Replacement of lost eyewear.
• Non-prescription (plan) lenses.
• Services not performed by licensed personnel.

Need more information? Please feel free to Visit our website at www.davisvision.com or call Davis Vision at 1-800-999-5431 to:

• Locate a network doctor in your area.
• Verify eligibility for yourself or a family member.
• Request an out-of-network provider reimbursement claim form.
• Speak with a Member Service Representative. Member service Representatives are available:

Monday through Friday, 8:00 AM to 8:00 PM, Eastern Time, and;
Saturday, 9:00 AM to 4:00 PM, Eastern Time. T.D.D. (Telecommunications Device for the Deaf) services are available by calling 1-800-523-2847.

• Ask any questions about your vision benefits.

To Order Replacement Contact Lenses By Mail (1-800-536-7123)

HERE'S HOW IT WORKS:

Just pick up the phone and dial 1-800-LENS 123. Identify yourself as a Vision Program Participant.

You'll be asked to fax or send your current contact lens prescription! If it's not handy, we'll get it for you. *

We'll ship your replacement contact lenses or solutions anywhere the very same day!**

IT'S THE SMARTEST WAY TO BUY REPLACEMENT CONTACT LENSES!

Guaranteed lowest prices on all name brand contact lenses.

Doctors of Optometry and highly trained professionals are available to answer any questions that you may have about contact lenses.

30-day money back guaranteed, if you are not completely satisfied with your contact lenses.

OVER 1 MILLION LENSES IN STOCK!

HERE'S A SAMPLE OF OUR GUARANTEED LOWEST PRICES ON NAME BRAND
LENSES",

<table>
<thead>
<tr>
<th>Product</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1DayAcuvue 3Dpk</td>
<td>$28.00</td>
</tr>
<tr>
<td>Focus Dailies 9Opk</td>
<td>$58.00</td>
</tr>
<tr>
<td>Acuvue 6 pk</td>
<td>$19.50</td>
</tr>
<tr>
<td>Surevue 6 pk</td>
<td>$19.50</td>
</tr>
<tr>
<td>Optima FW 6 pk</td>
<td>$19.50</td>
</tr>
<tr>
<td>Softens 66 6 pk</td>
<td>$19.50</td>
</tr>
<tr>
<td>Biomedic 6 pk</td>
<td>$24.00</td>
</tr>
<tr>
<td>Precision UV 6 pk</td>
<td>$21.50</td>
</tr>
<tr>
<td>NewVues 6 pk</td>
<td>$21.50</td>
</tr>
<tr>
<td>NewVues Softcolors 6 pk</td>
<td>$28.00</td>
</tr>
<tr>
<td>FreshLook LT 6 pk</td>
<td>$21.50</td>
</tr>
<tr>
<td>FreshLook Opaque</td>
<td></td>
</tr>
<tr>
<td>Colors 6pk</td>
<td>$33.00</td>
</tr>
<tr>
<td>FocusToric 6 pk</td>
<td>$62.00</td>
</tr>
<tr>
<td>MedalistGold Toric, 4 k</td>
<td>$65.00</td>
</tr>
<tr>
<td>CooperToric, 4 pk</td>
<td>$60.00</td>
</tr>
<tr>
<td>Ciba Visitint per lens</td>
<td>$25.00</td>
</tr>
<tr>
<td>Ciba Softcolors, per lens</td>
<td>$29.00</td>
</tr>
<tr>
<td>Edge III per lens</td>
<td>$19.00</td>
</tr>
<tr>
<td>Focus Visitint 6 pk</td>
<td>$45.00</td>
</tr>
</tbody>
</table>

* In some states, doctors may not be required to release contact lens prescription information.

* Some "Special Order" lenses may not be available for same day shipping. Prices are subject to change and do not include shipping.

**LASER VISION CORRECTION**

Members and their families can now save hundreds of dollars on these elective procedures which, traditionally, have been excluded from benefit plans. Members will be entitled to savings of up to 25% off usual and customary fees* ¼ or receive an additional 5% discount on any advertised specials – whichever is lower.

All surgeries, including PRK and LASIK, are performed at Davis’ Eye Centers of Excellence, staffed by renowned ophthalmologists and surgeons using the latest, most advanced instrumentation.

At Davis Vision, state-of-the-art technology and unsurpassed clinical expertise continue to provide client groups with unprecedented cost savings and optimum patient outcomes.

For more information, please visit the Davis Vision web site at:

www.davisvision.com

* Some centers offer flat rates equivalent to these discount levels due to market dynamics
FINANCIAL COUNSELING PROGRAM

Who is eligible...... All active and enrolled retired members.

What is the Benefit....This program was designed to provide a personal review of your finances and to help answer your financial questions.

You will have access to qualified professionals, Certified Financial Planners and Registered Investment Advisors who are available to work with you to provide objective and unbiased advice regarding: debt management, 403b allocations and decisions, retirement planning, insurance, investing, college planning, budgeting, 403b rollovers, and much more.

How to Obtain the Benefit.....To obtain this benefit, contact a representative of Stacey Braun Associates at 888-949-1925.
“(The assistance of counsel) is one of the safeguards of the Sixth Amendment deemed necessary to ensure fundamental human rights of life and liberty....The Sixth Amendment stands as a constant admonition that if the constitutional safeguards it provides be lost, justice will not still be done.”

United States Supreme Court Justice Hugo Black
Gideon v. Wainwright
**WHO IS ELIGIBLE?**

If you are eligible for Wappingers Congress of Teachers Welfare Fund Trust Fund benefits as an active member, you are eligible for legal services benefits. Your dependents are not eligible for legal services benefits unless specifically included in the benefit description.

**GENERAL RULES REGARDING COVERAGE**

*Enrollment*

To receive benefits, you must have completed a Wappingers Congress of Teachers Welfare Trust Fund ("Fund") Enrollment Form. The Enrollment Form provides the Fund with necessary basic information: your name, address, Social Security number, birth date, marital status, etc. If you have not completed an Enrollment Form, it is essential that you do so at the earliest possible opportunity.

All correspondence addressed to the Fund must contain the member’s name and address. Please notify the Fund Office, in writing, of any changes of name, address, etc. Maintenance of current records assures efficient processing of your claim and prompt receipt of your benefits.

*Appeals to the Board of Trustees*

The Board of Trustees of the Fund adopts rules and regulations for the payment of benefits and all provisions in this booklet are subject to such rules and regulations and to the Agreement and Declaration of Trust, which established the Fund and governs its actions.

A covered member may request a review of action taken by the Fund Office by submitting an appeal, in writing, to the Board of Trustees of Wappingers Congress of Teachers Welfare Trust Fund, 280 New Hackensack Road Wappingers Falls, New York 12590.

**HOW TO USE THE LEGAL SERVICES PROGRAM**

If you wish to make an appointment to consult a lawyer for benefits provided, call (914) 997-1576 and identify yourself as a Wappingers Congress of Teachers member.

You will be provided with an attorney from a panel law firm selected by the Fund. This firm will provide you with the benefits of the Fund. Your relationship with this law firm will be that of attorney and client. The attorney-client relationship will be exclusively between the covered member and the law firm. No employee of the Fund or any Trustee of the Fund can interfere in this relationship.

The Fund is designed to help pay for covered legal services. While the Fund cannot pay for all legal costs you have, it will help meet a substantial amount of such costs. You should explore with an attorney of the panel law firm the cost involved for any problem for which you seek help, so that you and the law firm, will have a working concept of what services are covered as well as what you will have to pay. Remember, however, that it is not always possible to estimate
total costs. When, after general consultation with the panel law firm, you decide to retain the panel law firm, you will then be required to make the appropriate payment as indicated in the plan of benefits.

You are not compelled to use the plan provided by the Fund. You are free at all times to select an attorney of your own choosing and to make payment to such an attorney for services. However, the Fund will not absorb or be responsible for any part of the fees or charges of attorneys other than those representing law firms on the panel for the legal services program.

You are also free at any time to discontinue the services of the panel law firm, and if you desire, to secure the services of a non-panel attorney. However, in such an event the Fund will neither be responsible for nor absorb any part of the fees or charges of non-panel attorneys. In addition, you continue to be obligated to the panel law firm for any cost incurred above the scheduled amount.

The panel law firm may, under exceptional circumstances, at any time (as is customary in the case of the independent retention of private attorneys) not undertake, discontinue or withdraw from representation of any covered member with appropriate adjustment of fees. In such cases, you are free to secure your own counsel. However, the Fund will neither absorb nor be responsible for any of the fees or charges of a non-panel attorney.

If you are an active member, you do not have to pay any subscription or registration fee to obtain the benefits of the Fund.

In instances where two covered members are involved in the same controversy or proceedings as adversaries, (and both members would have the right to the benefit under the rules of the Fund) each member will be provided access to an attorney, or provided with a stipend by the Fund, as determined by the Board of Trustees.

**REPRESENTATION IN CIVIL MATTERS**

The legal services benefits are divided into two major benefit categories: Representation in Civil Matters and General Legal Matters. All covered members are entitled to representation in no more than one (1) Civil Matter every calendar year. Should you require representation in additional Civil Matters in a calendar year, you may submit written request for consideration to the Fund’s Board of Trustees, which must include information supporting your need. Upon consideration of your request, the Trustees will render a written decision within a reasonable period of time. The following section concerns itself with the specific benefits within this category.

**LEGAL DEFENSE BENEFIT**

**Who is Eligible** . . . . . Any covered member who is a defendant in a situation involving his/her rights in resisting a claim and has had a legal action started against him/her, which does not fall within any of the specified benefits listed in this booklet.*
What is the Benefit . . . . . . The Fund provides coverage through the panel law firm for all necessary legal services arising from the defense of a lawsuit or proceeding commenced against a covered member in courts and administrative agencies. The following are only examples of some of the courts and agencies in which the Fund provides coverage under the Legal Defense Benefit:

As previously indicated, you are entitled to representation in no more than one legal defense matter every calendar year. Should you require representation in additional legal defense matters in a calendar year, you may submit a written request for consideration to the Fund’s Board of Trustees, which must include information supporting your need. Upon consideration of your request, the Trustees will render a written decision within a reasonable period of time.

If a covered member is sued jointly with another defendant, including a spouse, the matter will not be covered by the Fund unless special circumstances are presented to the Trustees and approved. You may submit a written request for consideration to the Fund’s Board of Trustees outlining your special circumstances to which the Trustees will render a written decision within a reasonable period of time.

Supreme, Surrogate's & District Courts of Westchester County; United States District Court for the Eastern and Southern Districts of New York; United States Customs Court; Supreme, Surrogate's and County Courts of Rockland, Orange, Putnam, Dutchess, Ulster, New York, Brooklyn, Queens, Richmond, Bronx, Nassau and Suffolk Counties; Civil Courts of New York, Brooklyn, Queens, Richmond and Bronx Counties; District Courts of Nassau and Suffolk Counties and Bergen, Hudson, Essex, Union and Middlesex counties in Northern New Jersey; Administrative Agencies and Bureaus.

*Please note: that special service benefits such as those involving divorce proceedings, separation proceedings, annulment proceedings, and homeowners proceedings are covered by the schedules contained under those specific headings in this booklet. This benefit provides, for example, the legal defense cost of a lawsuit alleging breach of contract or against lawsuits involving garnishment or medical expense claims.

A covered member's problem may be successfully resolved after consultation with a panel attorney or it may necessitate the steps leading to and including your defense in a litigation or before an administrative agency.

The following schedule indicates the legal services available and the amount to be paid by the member at each stage:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm.</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
</tbody>
</table>
B. Pre-litigation: Including for example negotiation of settlement including the drafting of any necessary papers $15

C. Litigation: Including, for example, third party complaint, demand for Bill of Particulars, preparation of Jury Demand and Court Appearance, if necessary $35

If the Legal Defense Benefit is concluded at the consultation stage there is no cost to the member. However, if the Legal Defense Benefit is concluded at the pre-litigation state, the cost to the member is $15; if the Legal Defense Benefit must enter the litigation stage, the cost to the member is an additional $35. Hence, the total cost to the member for a Legal Defense Benefit that reaches litigation is $50 ($15 + $35).

How to Obtain the Benefit. To obtain this benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

The acceptance of representation in all cases will be conditioned upon a determination by the panel law firm that the defense of the case is not frivolous. Such a determination will be made by the panel law firm and reported to the Trustees for a final determination.

Exclusions

• The legal defense benefit will not cover any controversy, action, dispute, proceeding or matter, which involves a member’s or their spouse’s business, commercial or investment interest.

• The legal defense benefit will not cover any controversy, action, dispute, proceeding or matter, which results from actions taken by a member or the member’s spouse acting on his/her own behalf as a general contractor for the construction of a new home or renovation of an existing home.

UNCONTESTED LEGAL SEPARATION BENEFIT

Who is Eligible. Any covered member who seeks a separation from his/her spouse by means of a separation agreement mutually agreed upon by the parties or any relief though the court by an action for an uncontested legal separation.

What is the Benefit. The Fund provides coverage through a panel law firm for all necessary legal services, which the preparation and negotiation of a separation agreement may require. The separation agreement may be prepared and executed with a minimum of consultation or it may necessitate extensive negotiation with opposing counsel and spouse.

The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:
Steps in the Legal Process Provided by
The Fund through the Panel Law Firm

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
<tr>
<td>B. Uncontested or cooperatively agreed separation with minimal negotiation</td>
<td>$45</td>
</tr>
<tr>
<td>C. Settlement after extensive negotiation</td>
<td>$75</td>
</tr>
</tbody>
</table>

Where the parties do not wish to enter into a separation agreement, an uncontested action in court for a legal separation may be had.

The following schedule indicates the legal services available in an uncontested separation and the amount to be paid by you in each circumstance:

Steps in the Legal Process Provided by
The Fund through the Panel Law Firm

<table>
<thead>
<tr>
<th>Steps</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
<tr>
<td>B. Litigation: including, for example, conference, preparation of Summons and Verified Complaint, documents relating to maintenance and support of children (in proper instances), Findings of Fact and Conclusions of Law</td>
<td>$180</td>
</tr>
</tbody>
</table>

How to Obtain the Benefit . . . To obtain the Uncontested Legal Separation Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

UNCONTESTED DIVORCE PROCEEDING BENEFIT

Who is Eligible. . . . Any covered member is entitled to this benefit.

What is the Benefit. . . . Divorce proceedings may be categorized as uncontested or contested. The Fund provides coverage for all steps of the legal process in the category of uncontested divorce proceedings.

The following schedule indicates the legal services available and the amount to be paid by you:

Steps in the Legal Process Provided by
The Fund through the Panel Law Firm

Uncontested Divorce -Coverage includes, for example,
the issuance of Summons and Complaint, Note of Issue, preparation of Findings of Fact, Conclusion of Law, Judgment and Entry of Judgment $60

**How to Obtain the Benefit** . . . To obtain the Uncontested Divorce Proceedings Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**UNCONTESTED ANNULMENT PROCEEDING BENEFIT**

**Who is Eligible** . . . Any covered member is entitled to this benefit.

**What is the Benefit** . . . Annulment proceedings may be categorized as uncontested or contested. The Fund provides coverage for all steps of the legal process in the category of uncontested annulment proceedings. The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by</th>
<th>Amount Paid by</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fund through the Panel Law Firm</td>
<td>Fund Member</td>
</tr>
</tbody>
</table>

A. Uncontested Annulment. Coverage includes, for example, Summons and Complaint, Note of Issue, Preparation of Findings of Fact, Conclusions of Law, Entry of Judgment and Finalization $60

**How to Obtain the Benefit** . . . To obtain the Uncontested Annulment Proceeding Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**ADOPTION BENEFIT**

**Who is Eligible** . . . Any covered member who seeks representation in an adoption proceeding.

**What is the Benefit** . . . The Fund will provide a covered member with an attorney from a panel law firm to represent the member in formal adoption proceedings. This benefit does not include payment of any fees or expenses to adoption agencies or any other agencies, but is limited to those services normally rendered by an attorney to formalize an adoption. After all arrangements have been agreed upon, the panel attorney will prepare all petitions and allied papers and will appear in court with the parties in support of the adoption, if required.

The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:
Steps in the Legal Process Provided by The Fund through the Panel Law Firm | Amount Paid by Fund Member
---|---
A. Consultation | None
B. Preparation of Documents and Court Appearance for adoption of child | $65

**How to Obtain the Benefit.** To obtain the Adoption Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

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**PERSONAL BANKRUPTCY BENEFIT**

**Who is Eligible.** All covered members are entitled to this benefit.

**What is the Benefit.** The Fund provides coverage through the panel law firm for all necessary conferences and legal services in the preparation of a petition to file for personal bankruptcy. Such a petition and schedules to file for personal bankruptcy may be finalized with a minimum of consultation and negotiation or it may involve a number of exceedingly complex steps. In some situations, it may require attendance at meetings with creditors and settlement agreements.

The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:

Steps in the Legal Process Provided by The Fund through the Panel Law Firm | Amount Paid by Fund Member
---|---
A. Consultation | None
B. Simple Personal Bankruptcy | $75
C. Complex Personal Bankruptcy | $100

**How to Obtain the Benefit.** To obtain the Personal Bankruptcy Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.
CHANGE OF NAME BENEFIT

Who is Eligible. . . . . Any covered member is entitled to this benefit.

What is the Benefit. . . . . This benefit provides legal advice and representation in the change of name procedure. Counsel will file all appropriate papers and represent the member in the change of name process.

The following schedule indicates the legal services available and the amount to be paid by the member at each stage:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by</th>
<th>Amount Paid by</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fund through the Panel Law Firm</td>
<td>Fund Member</td>
</tr>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
<tr>
<td>B. Actual change of name procedure</td>
<td>$45</td>
</tr>
</tbody>
</table>

How to Obtain the Benefit. . . . To obtain the Change of Name Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

HOMEOWNER'S RIGHTS BENEFIT

Who is Eligible. . . . . Any covered member who owns a private dwelling, a condominium or cooperative as a primary residence or is in the process of purchasing or selling such a primary residence or refinancing of a mortgage on a primary residence located within the geographic area covered by the Fund’s plan – Westchester; Rockland; Orange; Dutchess; Ulster; New York, Kings; Queens; Richmond, Bronx; Nassau and Suffolk Counties in New York and Bergen; Hudson, Essex, Union and Middlesex Counties in Northern New Jersey.

What is the Benefit. . . . . This benefit has two components:

(1) Legal advice or representation only for the sale or purchase of any private dwelling, condominium or cooperative in which the member primarily resides or plans to reside; or the purchase of unimproved property with the intention of building a home in which the member expects to primarily reside or the refinancing of a mortgage on a primary residence. The legal services plan does not provide representation in any phase of the construction of a home; including closing on a construction loan, or in any controversy, dispute, proceeding or matter arising from the construction of any home, including one in which the member expects to primarily reside, unless special circumstances are presented to the Trustees in writing and approved.

(2) Legal advice or representation in the defense of a mortgage foreclosure proceeding involving any of the above stated residences.
Regarding the first component of this benefit, the following schedule indicates the legal services available and the amount to be paid by the member in each instance:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by</th>
<th>Amount Paid by</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fund through the Panel Law Firm</td>
<td>Fund Member</td>
</tr>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
<tr>
<td>B. Negotiation, advice and representation in the sale, purchase or refinancing of a primary residence</td>
<td>$60</td>
</tr>
</tbody>
</table>

It should be noted that this benefit does not include any aspects of residential problems that involve Title searches or Title insurance nor the costs of same.

The second component of the Homeowner's Rights Benefit is legal representation through the panel law firm attorney in defense of a proceeding to foreclose a mortgage on a dwelling which the member owns and in which the member primarily resides. A mortgage foreclosure problem may be resolved after consultation with a panel attorney or it may require the contesting of any action to foreclose the mortgage in the appropriate court.

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by</th>
<th>Amount Paid by</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Fund through the Panel Law Firm</td>
<td>Fund Member</td>
</tr>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
<tr>
<td>B. Pre-litigation: including, for example Negotiation of settlement as well as the drafting of any necessary papers</td>
<td>$15</td>
</tr>
<tr>
<td>C. Litigation: including, for example, Demand for Bill of Particulars, Preparation of Jury Demand, Motions and Court Appearances</td>
<td>$125</td>
</tr>
</tbody>
</table>

**How to Obtain the Benefit.** To obtain the Homeowner's Rights Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**GENERAL LEGAL MATTERS**

As indicated before, the benefits of the Legal Services Program are divided into two categories: Representation in Civil Matters and General Legal Matters.

This section describes the General Legal Matters of the Fund. These benefits are provided to the members in those instances where the member's legal problems do not fall within the benefits provided within the Representation in Civil Matters category.
The following section describes the benefits included within the General Legal Matters category.

**GENERAL CONSULTATION BENEFIT (Three Each Year)**

**Who is Eligible. . . . .** All covered members.

**What is the Benefit. . . . .** This benefit provides covered members with an opportunity to consult with an attorney from the panel law firm for three one-half hour sessions each calendar year concerning any legal questions whatsoever*. This benefit is made available by the Fund at no charge to a covered member.

**How to Obtain the Benefit. . . . .** To obtain the General Consultation Benefit, simply contact the Fund to request a consultation appointment. At the time of the consultation, you and an attorney from the panel law firm will complete the appropriate forms.

*The General Consultation Benefit does not include representation. If such representation involves a covered matter, the Fund will pay the cost of representation in accordance with its Benefit Schedule. Of course, if the matter is not covered, any further legal costs must be borne directly by the member.

**DOCUMENT REVIEW BENEFIT***

**Who is Eligible. . . . .** All covered members are entitled to this benefit.

**What is the Benefit. . . . .** This benefit provides professional review and interpretation of all legal documents, such as: guarantees, warranties, installment purchase agreements, loans, leases, insurance policies and court papers, by an attorney from the panel law firm. There is no frequency limitation placed upon the utilization of this benefit, which is provided at no cost to the member.

**Exclusions and Limitations:**

The following documents are not included in the Document Review Benefit:

A. Tax Returns
B. Work that is being prepared by other attorneys at the time of the Document Review Benefit.

**How to Obtain the Benefit. . . . .** To obtain the Document Review Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.
The Document Review Benefit provides review and interpretation of documents only. The Document Review Benefit does not include representation. If such representation involves a covered matter, the Fund will pay the cost of representation in accordance with its Benefit Schedule. Of course, if the matter is not covered, then any further legal costs must be borne directly by the member.

**WILL BENEFIT**

**Who is Eligible. . . .** Any covered member and/or his/her spouse (if agreeable to the member) who wishes to execute a Will or have one reviewed or updated is covered by this benefit.

In addition, the parent or parents, or parent(s)-in-law, of a member who wishes to execute a Will or have one reviewed or updated is covered by this benefit.

**What is the Benefit. . . .** This benefit provides for the preparation and execution of a will, with a simple children's trust if appropriate, for the member and spouse under the supervision of an attorney from the panel law firm. The benefit is provided without charge, not more than once in every consecutive year period.

The Fund makes this benefit available at no charge to the member, his/her spouse, parent(s) or parent(s)-in-law.

**How to Obtain the Benefit. . . .** To obtain the Will Benefit, simply contact the Fund to request an appointment. If both member and spouse desire a Will, mother and father, or mother- and father-in-law, it is recommended that they make the appointment together. At the time of the appointment, the appropriate forms will be completed with the assistance of an attorney from the panel law firm. A second appointment will be scheduled for the execution (signing) of the completed will(s).

**PERSONAL INJURY (NEGLIGENCE) BENEFIT**

**Who is Eligible. . . .** A member and/or all members of his/her immediate family who has suffered a personal injury as a result of negligence is covered by this benefit.

**What is the Benefit. . . .** The Legal Services Program provides coverage through the panel law firm for all legal services, through trial if necessary, in connection with the prosecution of a claim for personal injury as a consequence of negligence in cases which legal counsel believes are worthy of prosecution.

The member will be represented on the basis of a contingent fee of 33-1/3% of the net sum recovered.

**What Does "Contingent Fee" Mean. . . .** It means that the fee is contingent upon successful recovery, whether by suit, settlement or otherwise. Thus, if there is no recovery, there is no fee. Conversely, the more that is recovered, the greater the fee...all dependent upon a successful conclusion of the matter.
As customary, whether the litigation is successful or not, you are required to reimburse the firm for all disbursements, charges and other expenses, such as: medical and police reports, investigations, witness fees, etc. Also, as is customary, in computing this contingent fee, liens in favor of hospitals, doctors, etc. or other statutory liens upon recovery, are not to be deducted. Such amounts would be paid out of the injured party's share of the recovery.

**How is the Personal Injury (Negligence) Benefit Obtained.** . . . . To obtain the benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**ARRAIGNMENT ASSISTANCE TELEPHONE CONSULTATION BENEFIT**

**Who is Eligible.** . . . . Any covered member or dependent who is a defendant in a criminal proceeding in Nassau, Suffolk, Westchester, Putnam, Dutchess, Rockland or Orange Counties, or the five boroughs of New York City.

**What is the Benefit.** . . . . The benefit provides coverage through the panel law firm for necessary legal telephone consultation assistance arising from an arrest, which may lead to immediate imprisonment.

This benefit provides, for example, the legal defense cost of the telephone assistance by an attorney, where the member/dependent is charged as the defendant in a criminal matter. It is important to note, however, that this benefit does not cover the costs of legal assistance beyond the telephone consultation arraignment assistance stage. Thus, if the member/dependent is interested in obtaining legal services beyond the telephone consultation arraignment assistance stage, he/she must make the necessary arrangements directly with the panel law firm or retain another attorney of his/her choice.

The following schedule indicates the legal services available and the amount to be paid by the member at each stage:

<table>
<thead>
<tr>
<th>Steps in the Legal Process Provided by The Fund through the Panel Law Firm</th>
<th>Amount Paid by Fund Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
</tbody>
</table>

**How to Obtain the Benefit.** . . . . To obtain the Arraignment Assistance – Telephone Consultation Benefit, the Fund must be contacted so that the appropriate arrangements may be made by the Fund with the panel law firm.

This service is available at any hour of the day or night by calling the special Fund number assigned to the program. 516-466-6030.
CONSUMER PROTECTION BENEFIT

Who is Eligible. . . . . Any covered member is entitled to this benefit.

What is the Benefit. . . . . This benefit provides members with coverage through the panel law firm for a broad range of legal services which might be needed to institute and pursue action against fraudulent practices by merchants, department stores, home repair contractors, public utilities, automobile dealers, appliance dealers, etc. Utilization of this benefit is limited to two matters per member, per calendar year, and the matter must involve a purchase costing $500 or more.

The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:

<table>
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<tr>
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<tbody>
<tr>
<td>A. Consultation</td>
<td>None</td>
</tr>
<tr>
<td>B. Representation by Written Communication</td>
<td>None</td>
</tr>
<tr>
<td>C. Litigation in Small Claims Court</td>
<td>$50</td>
</tr>
<tr>
<td>D. Litigation in Courts other than Small Claims Court</td>
<td>$100*</td>
</tr>
<tr>
<td>E. Representation with Appropriate Federal Agencies (e.g. F.T.C., etc.)</td>
<td>$100*</td>
</tr>
</tbody>
</table>

* If a lawsuit involves a consumer purchase of $5,000 or more -e.g., "Lemon" car -then the cost to the member for litigation or representation shall be $250.00.

NOTE -Some legal services not provided under this benefit include, but are not limited to, suits for punitive damages, class actions and commercial enterprises.

How to Obtain the Benefit. . . . . To obtain the Consumer Protection Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

IDENTITY THEFT PROTECTION BENEFIT

Who is Eligible…Any member who wishes legal consultation in connection with an identity or personal information theft issue is covered by this benefit.

What is the Benefit…Fund provides coverage through the panel law firm for a member to consult with an attorney if the member believes he/she has been the victim of an act of identity or
personal information theft including but not limited to the following examples:

- using or opening of a credit card account in the member’s name, fraudulently;
- opening telecommunications or utility accounts in the member’s name, fraudulently;
- passing bad checks or opening a new bank account in the member’s name, without authorization; and
- obtaining a loan in the member’s name, fraudulently.

The panel law firm will provide consultation and assistance* to a member in connection with their contacting and reporting an act of identity theft to the three major credit bureaus, the security departments of the appropriate creditors or financial institutions, the police and the Federal Trade Commission.

The Fund makes this benefit available at no charge to member.

**How is the Identity Theft Benefit Obtained**…To obtain the Identity Theft Benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

*The Identity Theft Benefit does not include representation in litigation other than that already provided in the Consumer Protection Benefit.

**LIVING WILL/HEALTH CARE PROXY BENEFIT/POWER OF ATTORNEY**

**Who is Eligible. . . . .** You are eligible if you are a covered member or a covered member's spouse, a covered member’s parent(s) and/or a covered member’s parent(s)-in-law, if agreeable to the member. Health care proxies and durable powers of attorney are also covered for adult children of members, provided the adult child appoints the member his/her representative/proxy.

**What is the Benefit. . . . .** This benefit provides you, your spouse, you parent(s) and/or parent(s)-in-law with the opportunity to have a living will/healthcare proxy/power of attorney prepared and executed under the supervision of an attorney from the panel law firm. This benefit is provided once every two calendar years at no cost to you.

A living will and/or health care proxy serves as a clear documented expression of an individual's carefully considered intention to have life-sustaining procedures withheld or withdrawn if he or she were to suffer from a catastrophic illness, disease or injury from which there is little likelihood that he or she would recover to enjoy a meaningful quality of life.

A power of attorney appoints an individual of your choosing to conduct your affairs immediately or upon the happening of a catastrophic event, which results in your incapacity.
How to Obtain the Benefit. . . . To obtain the Living Will/Health Care Proxy/Power of Attorney Benefit, either you or your spouse should contact the Fund to request an appointment. If both husband and wife desire a living will/health care proxy/power of attorney, it is recommended that you make an appointment together. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS BENEFIT

Who is eligible...Any covered member, covered member’s spouse, covered member’s parent(s) and/or parent(s)-in-law.

What is the benefit...This benefit provides you, your spouse, your parent(s), and/or parent(s)-in-law with the opportunity to have an Appointment of Agent to Control Disposition of Remains document prepared and executed under the supervision of an attorney from the panel law firm.

An Appointment of Agent to Control Disposition of Remains serves as a clear documented designation of a burial agent and expression of special directions of how the individual’s burial is to be accomplished.

The Fund makes this benefit available at no charge to member.

How is the benefit Obtained...To obtain the Appointment of Agent to Control Disposition of Remains benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

PLANNING FOR THE ELDERLY BENEFIT

Who is Eligible. . . . You are eligible if you are a covered member or a covered member's spouse, a covered member’s parent(s) or a covered member’s parent(s)-in-law.

What is the Benefit. . . . This benefit provides you, your spouse, your parent(s) and/or parent(s)-in-law with an opportunity to consult with an attorney from the panel law firm on matters involving, e.g., the placement of elderly parent(s) in nursing homes, available Medicare entitlement and health planning for the elderly. This benefit includes the preparation of powers of attorney and is offered at no cost to you.

How to Obtain the Benefit. . . . To obtain the Planning for the Elderly Benefit, either you or your spouse should contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms with the client.
ESTATES AND ADMINISTRATION BENEFIT

Who is Eligible. You are eligible if you are a covered member or a covered member's eligible dependent who is named as Executor in a Will. You are also eligible if you are named as executor in a will by a covered member. If there is no Will, you or an eligible dependent who would qualify under intestacy laws to serve as Administrator of the estate will be eligible.

What is the Benefit. This benefit provides all legal services, which may be required in connection with the handling of an estate from its inception (the probate of a Will or Petition for Letters of Administration where there is no Will), through all phases of estate administration including tax proceedings and "winding up" of the estate (through accounting and distribution).

With respect to the estate of a deceased member, these services are provided to the surviving spouse or eligible dependent children in those instances where the spouse or eligible dependent children would be entitled to be appointed Executor or Administrator.

PLEASE NOTE: This benefit does not provide legal services of an adversarial nature, e.g., to contest an existing will.

Steps in the Legal Process

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Nothing</td>
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The panel law firm has agreed to provide legal representation in these matters with a 25% reduction in its regular hourly rate, which for 2019 is $450 (this is $337 per hour). The panel law firm’s regular hourly rate may be subject to change each year. The retainer for these legal services is between the state representative and the law firm. It should be discussed and executed at the initial appointment.

How to Obtain the Benefit. To obtain the Estates and Administration Benefit, simply contact the Fund to request an appointment. At the time of the appointment, you and an attorney from a panel law firm will complete the appropriate forms.

ESTATE PLANNING BENEFIT

Who is Eligible. You are eligible if you are a covered member, a covered member’s spouse or domestic partner (if agreeable to the member) or a covered member’s parent(s) and/or parent(s)-in-law.

What is the Benefit. This benefit provides covered members and their spouses/domestic partners, parent(s) and/or parent(s)-in law with the opportunity to have estate planning trusts prepared and executed under the supervision of an attorney from the panel law firm.
The following schedule indicates the legal services available and the amount to be paid by the member:

<table>
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<th>Steps in the Legal Process</th>
<th>Amount Paid by</th>
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<tbody>
<tr>
<td>A. Consultation</td>
<td>$250.00*</td>
<td>The Fund Member</td>
</tr>
<tr>
<td>B. Preparation and execution of certain estate Planning trusts, as follows:</td>
<td>20% Off U&amp;C Fee**</td>
<td></td>
</tr>
</tbody>
</table>

- **Irrevocable Life Insurance Trust ("ILIT")** - Designed to remove life insurance proceeds from the insured’s and the surviving spouse’s taxable estate.
- **Revocable Grantor Trust (Living Trust)** – Created during a person’s lifetime and can be amended or revoked by the grantor at any time.
- **Supplemental Needs Trust (Escher Type Trust)** – Allows a person receiving governmental assistance (Medicaid) to receive prescribed amounts of income and principal from trust without jeopardizing governmental assistance.
- **Marital Trust** – A trust, which is containing specific statutory provisions will qualify for the marital deduction, and therefore not be included in the decedent’s taxable estate.
- **Qualified Personal Residence Trust ("QPRT")** – Allows a person to place his or her personal residence in a trust and continue to have full use of the trust for a number of years, providing such term is less than the grantor’s life expectancy.

*To be credited to fee for preparation of trust.*

**Usual and customary fee charged by the law firm for 2019 is $4,500 per trust for all trust except QPRT trusts, which is $3,700 per trust. Fees may change year to year.

**How to obtain the Benefit. . . . .** To obtain the Estate Planning Benefit, you should contact the Fund to request an appointment.

**DESIGNATION OF PERSON IN PARENTAL RELATION**

**Who is Eligible**…You are eligible if you are a covered member.

**What is the Benefit**…This benefit provides the covered member with the opportunity to have a Designation of Person in Parental Relation (“Designation”) prepared and executed under the supervision of an attorney from the panel law firm.

A Designation designates another person (the “Designee”) as a person in parental relation to a minor or incapacitated person to act on his/her/their behalf in matters relating to education and health care. The Designation is a very useful document for parents who must leave their child with a caregiver for a limited period of time. If drafted properly, the Designation will be valid for up to 6 months.
NOTE: With respect to a covered member who wishes to be named Designee, an attorney from the panel law firm will provide a special consultation to confirm that a Designation one may receive is in conformity with the law.

How to Obtain the Benefit…To obtain the Designation of Person in Parental Relation Benefit, you should contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

COUNSELING OF UNEMANCIPATED* CHILDREN BENEFIT

Who is eligible…Upon application of the member/parent, your unemancipated child, who is over 18 years of age and qualifies as an eligible dependent child (as defined by the rules of the Fund).

What is the benefit…The Fund provides coverage through the panel law firm for consultation and document review services to your unemancipated child on matters involving the following:

- Legal responsibilities that affect your child when they turn age 18, whether or not they are emancipated;
- Contract review;
- Lease review and real estate issues;
- Agreements and documents associated with educational institutions (i.e. universities and colleges);
- Loan agreements and other credit matters; and
- Identity theft matters.

How is the Counseling of Unemancipated Children Benefit obtained…To obtain the Counseling of Unemancipated Children Benefit, simply contact the Fund to request an appointment for your child. At the time of the appointment, your child and an attorney from the panel firm will complete the appropriate forms.

Exclusions:

Excluded from the Counseling of Unemancipated Children Benefit is advice or consultation in any controversy, dispute or proceeding with the covered member/parent.

*An unemancipated child is any dependent child (as defined by the rules of the Fund) who is over 18 years of age and fully dependent on you/the member for support.

GENERAL EXCLUSIONS FROM ALL BENEFITS OF THE LEGAL SERVICES PROGRAM

All legal services provided by the Fund have been specifically stated and described. Any legal service that has not been so described can be considered excluded from the Plan of Benefits.
However, in order to guide the member in his/her utilization of the Legal Services Program benefit package, this section lists specifically, but without limitation, particular exclusions from the Plan:

- Any controversy, dispute or proceeding with or against the employer or the employer's agents or officers;

- Any controversy, dispute or proceeding directed against the Union or any of its affiliated bodies, e.g., the Fund, or any of the officers, agents or attorneys of the Union and its affiliated bodies;

- Any controversy, dispute or proceeding in which the Fund would be prohibited from defraying the cost of legal services by any provisions of the law;

- Any controversy, action or proceedings in which representation on a contingent fee basis is normally and customarily available or where the fee is payable by virtue of statute or by order of court;

- Class actions or interventions or amicus curiae activities. Two or more parties may not pool or combine their benefits for the purpose of asserting a claim in which they have a mutual interest;

- Any matter concerning the preparation or filing of income tax returns or payment of income tax;

- Any controversy, action, proceeding or dispute in which the legal services are available through insurance or through any government agency or attorney (Federal, State or local);

- Any controversy, dispute or proceeding in which the member was previously represented by an attorney;

- Any legal expenses incurred for a matter which commenced before the member became eligible to receive a benefit under the Plan;

- Any controversy, dispute, proceeding or matter that cannot be litigated or otherwise handled within Rockland, Dutchess, Putnam, Orange, Ulster, Nassau, Suffolk or Westchester Counties, the five boroughs of New York City or the five Northern Counties of New Jersey, as described in the Legal Defense Benefit section;

- Any controversy, dispute, proceeding or matter which involves a member's business, commercial interest or investment matters;

THE FUND WILL NOT PAY:

- for services or advice when such activity involves a duplication of the same service or advice previously obtained in connection with the same problem and previously claimed for under the Plan;

- court costs and/or filing fees, nor in any event will the Fund pay fines, penalties or any amounts in which a member may be cast in judgment.

IF YOU HAVE ANY QUESTIONS WITH REGARD TO COVERAGE, BENEFITS OR EXCLUSIONS, PLEASE CONTACT THE FUND OFFICE