CCTA
Benefit Trust Fund

GROUP BENEFITS BOOKLET

Dental and Vision: Plan
Arranged & Administered by
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WHERE TO FIND CLAIM FORMS:

Cornwall Central Teachers' Association website, www.cornwallteachers.org , Printable Materials
Fitzharris & Co. Inc. website, www.fitzharrisinsurance.com, Claim Forms
Davis Vision's website, www.davisvision.com or call 1-800-575-0199

WHEN SHOULD YOU SUBMIT A CLAIM?

When you have a claim you should promptly submit the completed claim form and any bills or receipts. We have the right to reject claims submitted more than 180 days after the service. A late claim might be accepted if it is not reasonably possible to submit the claim during the 180 days.

Please note: Benefit checks are **VOID** after 90 days. Please cash promptly.

HOW TO FILE YOUR CLAIM FORMS:

- Electronic Claim Filing – Electronic Claims can be submitted by your provider. Fitzharris' Payer Number is 11244 for dental & vision claims.
- The top portion of the Claim Form entitled "Employee's Section" on the dental/vision form must be fully completed.
- The group name and code, **C.C.T.A.B.T. 0713,** should be written in the **GROUP** space on each form.
- If the Claim is for yourself, your coverage is the primary plan. If the claim is for your spouse and he/she has other coverage, be sure to attach the payment voucher or declination from his/her plan. If the claim is for your dependent children and your birthday (month and day) is earlier in the calendar year than your spouse's, you should file first. If your spouse's birthday is earlier, you must file with your spouse's plan first, and attach copies of their payment voucher to the claim you are filing through our plan.
- Either have the provider complete his portion of the form or attach itemized bills to the completed form.
- Completed forms should be mailed to the Claims Administrator, Fitzharris Administrator Inc., at the address which appears on the claim form.

SYNOPSIS OF BENEFITS

EMPLOYEES ELIGIBLE: As defined.

DEPENDENTS ELIGIBLE: All dependents as defined.

PLAN CONTRIBUTIONS: As determined by the CCSD - CCTA Contract

DENTAL BENEFITS FOR YOU AND YOUR DEPENDENTS:

PREVENTIVE DENTAL EXPENSE BENEFIT
Preventive Care Cash Deductible - None (Each Covered Person - per Benefit Year)

BASIC DENTAL EXPENSE BENEFIT
Cash Deductible - $25.00*
(each Covered Person - per Benefit Year)
Family Deductible Limit - $75.00

MAJOR DENTAL EXPENSE BENEFIT
Cash Deductible - $25.00*
(each Covered Person - per Benefit Year)
Family Deductible Limit - $75.00

Maximum Dental Benefit - $1,500.00 ** per benefit year.

* The Cash Deductible is a combined deductible for all services under the Basic and Major Dental Expense Benefits.

* * The Maximum Benefit is a combined maximum for all services under the Preventive, Basic and Major Dental Expense Benefits.

A BENEFIT YEAR is a period of time which starts on July 1 of each year and ends on June 30 of the next year (12 months).

DENTAL PARTICIPATING PROVIDER NETWORK

Fitzharris & Company, Inc. and Aetna each have a **Participating Provider Network** for dental services. These providers have agreed to limits on the amounts they charge for dental services, and are dedicated to giving you high quality, cost effective care. When you visit a participating provider, your out-of-pocket payment will generally be substantially lower than when you visit a non- participating provider. Payment will be made directly to the participating provider. A list of these providers can be found on the Fitzharris & Company, Inc. and Aetna websites. It is very important that you ask your provider if he (she) participates in the Fitzharris & Company, Inc. or Aetna **Participating Provider Network.** If your provider does participate, the payment will be mailed directly to the dentist. You will then be responsible for any unpaid balance.

VISION BENEFITS FOR YOU AND YOUR DEPENDENTS:

One of each of the following two items is covered in a Policy Year:

(1) Routine Eye Examination; and
(2) Eyeglasses and Frames or Contact Lenses.

For more details consult your Claims Administrator, Fitzharris Administrators Inc.

IMPORTANT: Read this document carefully. See “Definitions” and “What Expenses are Not Covered” for other conditions that may affect the coverage.

Both the current **CCTA Benefit Trust** and the **Fitzharris & Company, Inc. PPO Dental Schedules** are available in PDF format on the Cornwall Central Teachers’ Association website at www.cornwallteachers.org.

HEALTH ADVOCATE

Effective July 1, 2005, all members and their families have access to a unique new service offered by Health Advocate. This service is available to you, your spouse, your dependents, parents and in-laws regardless of whether or not they are covered by **Cornwall Central Teachers' Association Benefit Trust** plan of benefits.

Health Advocate is an **independent** company that is made up of professional individuals such as nurses, doctors, psychologists, etc. These professionals are now available to our members and families to help you navigate the healthcare system. Health Advocate is designed to help handle healthcare and insurance related issues by cutting through the red tape and barriers that so often create frustration and problems. For more comprehensive details of this service, please visit www.healthadvocate.com .

Health Advocate does **not** replace the customer service line of our health plan, nor is it a nurse hot-line for emergencies. It is an organization of qualified individuals who will use their expertise in the health field and knowledge of providers across the country. It is a service to obtain confidential, unbiased, objective information and to help you make choices concerning your health situation. Too many times patients are uncertain that they are getting all of the information or the correct information. Health Advocate is here to remove that uncertainty.

Some examples of the reasons to call Health Advocate are:

1) To identify and make appointments to see the best physician or hospital for an illness.
2) For help understanding an illness when you have been unable to get the time with your provider to ask all your questions.
3) For help with insurance claims and billing issues.
4) For help with medical issues and healthcare needs that your parents or in-laws might have (they are also eligible for the service).
5) Assistance with understanding any issues with your prescription drugs.

Health Advocate **does not deliver medical care** nor do they tell the members what to do. Instead they help you make more **informed decisions** about your healthcare. A Health Advocate nurse will answer your questions, do the research, provide you the options and follow up with you. Simply call Health Advocate at 1-866-695-8622. There are no enrollment forms. When you call Health Advocate and require service, they will ask you to complete a Medical Information Release Form. Please be assured that all of your information will be kept strictly confidential by Health Advocate and your privacy will be protected.

WHO IS ELIGIBLE AND WHEN COVERAGE BEGINS

WHO IS ELIGIBLE FOR COVERAGE?

You are eligible for coverage if you are in an eligible class. There are three eligible classes.

Eligible Classes -

Class A - Active CCTA members who are contracted for employment for a minimum of 90 days.

Class B - Administrative personnel designated by the Trustees of the CCTA.

1. Who have been reported by the District for Social Security purposes for a period of ninety days; and
2. Who work at least 20 hours per week.

Class C - Retirees who have elected and maintained COBRA coverage as of July1, 2001.

Your following dependents, if any, are also eligible for coverage:

1. Legally married spouse or Domestic Partner. Legally separated spouse or divorced spouses are not covered.

2. Each of your unmarried children: who are under 19 years of age; or who are full-time college students under 26 years of age and are dependent upon you for support; or stepchildren, adopted children, or foster children who are dependent upon you for support.

3. Dependent students are covered until the earlier of Age 26 or the end of the plan year in which they graduate.

Exceptions - The dependent age limit does not apply to handicapped dependent children. You may be required to show proof of handicapped status once a year.

Mentally or Physically Handicapped Children

If a Covered **Dependent** child:

(a) reaches the age at which he would otherwise cease to be a Covered **Dependent**; but
(b) is then mentally or physically incapable of earning his own living; and
(c) is primarily dependent upon you for support; and if
(d) you submit satisfactory proof of the child's incapacity within 31 days of the date the child reaches such age,

then coverage may continue for such child for as long as he remains incapacitated, subject to payment of required contributions and all other terms of the plan.

HOW DO YOU ENROLL?

You enroll for coverage by completing a Request for Coverage form which is available from the Cornwall Central Teachers' Association Benefit Trust Fund. If you wish to cover any eligible dependent, 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.

If both you and your spouse are members of the group, both of you may elect dependent coverage.

WHEN DOES YOUR COVERAGE BEGIN?

For Class A and Class B membership, coverage begins on the later of July 1, 1992 or the first day of the month after you begin work.

For both classes A and B, the member must be actively at work at the Employer'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.

For Class C, elected coverage will begin upon retirement and will continue as long as COBRA payments are maintained. Note: Retirees must sign up for COBRA within thirty (30) days of retirement.

WHEN DOES A DEPENDENTS COVERAGE BEGIN?

If you have enrolled for dependent coverage, coverage for your eligible dependents begins on the date your coverage begins. Dependents you later acquire will become covered on the day they become eligible dependents.

IF YOU DO NOT ENROLL PROMPTLY?

You should enroll promptly. Coverage for your dependents cannot begin before the date you enroll. If you enroll your dependents more than 31 days after that date, dependents coverage will be limited during the first 24 months. See—LATE ENTRANTS.

LATE ENTRANT

The following applies only to Dental Coverage if provided on a Contributory Basis:

LIMITATION FOR LATE ENROLLEES - DENTAL
If you or any of your Dependents become covered later than 31 days after the date on which you or such Dependent becomes eligible, then there will be no coverage under these Parts until you or such Dependent has been covered for:

(1) 6 months under Diagnostic & Preventive Services, other than for routine oral examinations and x-rays; and

(2) 24 months under Basic and Major Services.

RETIRED MEMBER COVERAGE

Members who retiree on or after June 30, 2001, and have maintained COBRA coverage as of July1, 2001 are eligible to continue dental and vision coverage into retirement on a self-pay basis. Coverage will continue until the earlier of:

- the plan ceases:
- you fail to make the required payments.

If coverage lapses due to failure to make timely payments, there will be no reinstatement.

Retiree coverage is not automatic. You must complete an election form and return it to Fitzharris & Co. with payment.

COBRA (See COBRA section in this booklet) rules apply to retiree dental coverage. The exception is there is no set limit to the number of months you can be extended coverage.

DEFINITIONS

Alternative Benefits
If: (1) there is a less costly alternative to any service or supply which is:

proposed; or
furnished; or
provided; and

(2) such alternative is within accepted standards of dental practice;

then only the **Reasonable Charge** for such alternative shall be considered to be **Covered Expense.**

Benefit Year
A 12 month period beginning July 1st and ending June 30th.

Covered Expense
A **Reasonable Charge** incurred by a **Covered Person** for a **Necessary Service or Supply** which appears on a List of Covered Expenses.

Customary Charge
The charge usually made by **Dentists** for a given service within the locality where the service is rendered.

Dental Hygienist
A person who:

- is licensed to practice dental hygiene; and
- works under the direct control and supervision of a **Dentist**.

Dentist
A licensed **Dentist** who is practicing within the scope of his license.

Domestic Partner
Domestic Partner means your unmarried opposite sex or same sex life partner who:

1 Is eighteen (18) years of age or older;
2 Resides with you, sharing the same permanent residence for at least (12) consecutive months, with the current intent to continue doing so indefinitely;
3 Is not married to or separated from anyone else under applicable state law, nor have had another domestic partner within the prior 12 months;
4 Is not related to you by blood;
5 Is financially interdependent evidenced by basic financial obligations (i.e. joint bank accounts, joint credit cards, joint ownership of a residence, household expenses, granting power of attorney, designating each other as sole beneficiary/executor) or evidence of other joint financial responsibilities.
6 With you, is jointly financially responsible for basic living expenses.

Family Member
Refers to you or any of your eligible dependents covered under the plan.

Incurred Expense
Except as noted below, an expense is deemed to be incurred on the date a service is rendered or a supply is furnished.

EXCEPTIONS

- Expense for an appliance or modification of an appliance is deemed to be incurred on the date the master impression is made.
- Expense for a crown, a bridge, or an inlay or onlay restoration is deemed to be incurred on the date the tooth is prepared.
- Expense for root canal therapy is deemed to be incurred on the date the pulp chamber is opened.

Lifetime Maximum Benefit
The total amount of benefits that will be available to a Covered Person during his lifetime.

Maximum Benefit
The total amount of benefits that will be available to a Covered Person during a Benefit Year.

Necessary Service or Supply
A service or supply that is generally considered by **Dentists** to be an appropriate dental service or supply for a given dental condition.
For purposes of this plan, The Plan Administrator reserves the right to determine:

(1) **Usual Charges**; and
(2) **Customary Charges**; and
(3) **Reasonable Charges**; and
(4) **Necessary Services or Supplies**

Pre-Determination of Benefits
A **Dentist's** report to the Claims Administrator which:

- is on a claim form; and
- lists the dental services he proposes to render to a **Covered Person**; and
- shows his charge for each service; and
- is accompanied by pre-treatment x-rays or other diagnostic data which The Claim Administrator may require.

Reasonable Charge
A charge which is both **Usual** and **Customary** for the service rendered

Usual Charge
The charge usually made by an individual **Dentist** for a given service.

DENTAL CARE BENEFITS

WHAT IS THE DEDUCTIBLE?

Generally, you must pay the first $25 of a FAMILY'S Covered Expenses each benefit year.

Family Limit
You do not have to pay more than a total of $75 per benefit year.

Covered Expenses Not Subject to Deductible
Covered Expenses for Diagnostic and Preventive services are not subject to the Deductible.

"FAMILY MEMBER" means you or any of your eligible dependents covered under the Plan's Dental.

WHAT DO WE PAY?

We will pay the following amount of your Covered Expenses:

These expenses are subject to reasonable and customary allowances as determined by the Plan Administrator.

1. We will pay 85% of reasonable and customary allowances for **Diagnostic and Preventive Expenses**. Reasonable and customary allowances are determined by the Plan Administrator. Diagnostic and Preventive Expenses are not subject to the plan deductible.

2. After you pay the Deductible, 100% of all other "Covered Expenses" according to the current Plan Schedule for **Basic and Major Dental Services**. This is also true for each family member.

Is There a Maximum Benefit?

The maximum we will pay for all Covered Expenses of a family member during a benefit year is $1,500.00.

Should Benefits Be Determined Before Treatment Begins?

One of the advantages of this dental plan is that it enables you to see the amount payable by the plan prior to having your dentist begin any extensive treatment. This procedure is known as a Pre-determination of Benefits. Through this process, you can prevent any misunderstanding as to what is covered by the dental plan. Benefits should be pre-determined before you begin treatment if the charges for the treatment will be more than $400.00.

A dental claim form should be completed and submitted to the Claims Administrator, Fitzharris Administrators, Inc. The Claims Administrator will advise you and your dentist of the approved covered dental procedures.

When Is A Charge Incurred? A charge is incurred on:

(a) the date the impression is taken, in the case of dentures or fixed bridges.

(b) the date the preparation of the tooth is begun, in the case of crown work.

(c) the date the work on the tooth is begun, in the case of root canal therapy.

(d) the date the work is done, in the case of any other work.

What If More Than One Method Of Treatment Is Available?
When more than one method of treatment is available, we will pay for Covered Expenses for the least expensive method of treatment, regardless of which method is actually used. Examples of this are: restoring teeth with a crown when the tooth could be restored with a filling; fixed bridgework when a partial denture would provide a similar result.

WHAT ARE COVERED EXPENSES?

Covered Expenses are charges by a dentist for necessary dental services furnished to a covered person under the Plan. There are three types of Covered Expenses: Preventive Expenses, Basic Dental Expenses, and Major Dental Expenses. For most services the amount counted as a Covered Expense is determined from the Schedule of Covered Dental Services. Not all expenses are covered. See—WHAT EXPENSES ARE NOT COVERED?

What are Preventive Expenses?
Preventive Expenses are the following:

ORAL EXAMINATIONS - periodic during regular office hours (limited to 2 a benefit period).

EMERGENCY EXAMINATION - one per policy year.

PROPHYLAXIS, including the scaling and polishing of teeth (limited to 2 a benefit period).

TOPICAL APPLICATION OF FLUORIDE limited to two treatments per benefit year for children under age 19.

BITEWING X-RAYS (not more than twice a year).

FULL-MOUTH SERIES OF X-RAYS, including bitewings (limited to once every 3 years).

PANORAMIC SURVEY (considered full mouth series) limited to once every 3 years.

SPACE MAINTAINERS—Charges for space maintainers for missing primary teeth.

What are Basic Expenses?

Basic Dental Expenses are for the following services:

ORAL SURGERY—Charges for surgery performed on the gums, alveolar processes and teeth. This includes removal of impacted or erupted teeth and preparation of the gums for dentures.

EXTRACTIONS—Charges for extractions, including those in connection with orthodontic treatment. (Includes local anesthetic and post-operative care.)

ANESTHESIA—Charges for general anesthesia administered in connection with covered surgical procedures. The anesthetic agent must produce a state of unconsciousness with absence of pain over the entire body.

PERIODONTICS—Periodontal charting and mounted original full mouth x-rays are required for all periodontal procedures. If more than one surgical service is performed per quadrant, only the most inclusive surgical service performed will be considered a covered dental service. Flap entry and closure is considered part of the dental service for osseous surgery and osseous graft. Periodontal procedures include: periodontal scaling/root planning

(limited to 4 quad per year), gingivectomy or gingivoplasty, osseous surgery.

ENDODONTICS—Charges for root canal therapy, includes necessary x-rays.

FILLINGS—Charges for amalgam and composite fillings, other than gold fillings. Composite restorations are covered charges and limited to the first ten teeth in each arch.

SEALANTS - Limited to permanent molar teeth, once every 3 years.

What are Major Expenses?

Major Dental Expenses are for the following services:

RESTORATIONS—Restorative Cast Restorations, crowns, inlays and onlays are covered only when necessitated by decay or traumatic injury and the tooth cannot be restored with a routine filling material.

BRIDGES AND DENTURES—Charges for initial installation of dentures or fixed bridgework to replace at least one natural tooth extracted while the family member is covered under the Plan's Dental Care Program.

REPLACEMENT WORK—Charges for replacement of existing crowns, inlays, onlays, dentures or fixed bridgework if the existing was installed at least five years prior to its replacement and cannot be made serviceable. The replacement must not be needed because of the loss or theft of the crown, inlay, onlay, dentures or fixed bridgework.

Also, charges for replacement of existing dentures or fixed bridgework, or for the addition of teeth to existing dentures or fixed bridgework, if needed to replace at least one natural tooth extracted while the family member is covered under the Plan's Dental Care Program.

REPAIR WORK—Charges for repair and recementing of crowns, inlays and fixed bridgework.

WHAT EXPENSES ARE NOT COVERED?

The following charges are **not** covered or are covered only to the extent stated.

1. OCCUPATIONAL INJURY—Charges due to an on-the-job injury are not covered. However, this exclusion will not apply if the law does not permit a family member's employer (or the family member) to obtain coverage for the family member under a Workers' Compensation Act or similar act. Nor will it apply if the law permits but does not require a family member who is a partner or an individual proprietor to have coverage under a Workers' Compensation Act or similar act and that person does not have such coverage.

2. OCCUPATIONAL SICKNESS—Charges due to any sickness which would entitle the family member to benefit under a Workers' Compensation Act or similar act are not covered.

3. GOVERNMENT SERVICES—Charges for dental services furnished by or paid for by any government or government agency are not covered. Charges for dental services are not covered if the family member would not have been required to pay for the services in the absence of insurance for dental care. However, this exclusion will not apply where prohibited by law.

4. COSMETIC DENTISTRY—Charges in connection with dental services primarily for the purpose of improving appearance are not covered. For example, the following are **not** covered:

   alteration or extraction and replacement of sound teeth

   porcelain or other veneer crowns or pontics to replace molar teeth

   porcelain or other veneer facings on crowns or pontics to replace molar teeth

composite or plastic fillings placed in molar teeth

any treatment of the teeth to remove or lessen discoloration except in connection with endodontic treatment; replacement of congenitally missing teeth;

5. Replacement of existing dentures or fixed bridgework, or addition of teeth to existing dentures or fixed bridgework, unless:
   (I) the replacement or addition is needed to replace at least one natural tooth extracted while the family member is covered under the Dental Plan; or
   (ii) the existing denture or fixed bridgework was installed at least five years prior to the replacement and cannot be made serviceable. However, this exclusion will not apply to any such replacement which is required because of accidental bodily injury which a covered person sustains while covered under this plan.

6. Replacement of lost or stolen crowns, dentures or fixed bridgework.

7. Appliances, restorations, or procedures for:
   a. altering vertical dimension; or
   b. restoring or maintaining occlusion; or
   c. splinting; or
   d. replacement of tooth surface lost by abrasion or attrition; or
   e. treatment of dysfunction of the temporomandibular joint (TMJ), unless specifically included in your booklet.

8. MISCELLANEOUS SERVICES—Charges for oral hygiene instruction, plaque control, dietary instructions.

9. SERVICES BY RELATIVES—Charges for dental care furnished by any person related by blood or marriage.

10. Charges for Implantology, and any prosthetic or crown used in conjunction with such implant are also not covered.

11. Any service or supply which is not customarily performed, not reasonably necessary for dental care or treatment, or is experimental nature

12. Any service or supply which is not furnished by a Dentist, except:

    a. A service performed by a Dental Hygienist working under supervision of a Dentist; and
    b. X-rays ordered by a Dentist.

TREATMENT STARTED BEFORE COVERAGE BEGINS—

Charges for the following are **not** covered:

Dentures, if the impression for the denture was taken before the family member became covered under the Dental Care Plan; crowns, bridges or gold restorations if preparation of the teeth was begun before the family member became covered under the Dental Care Plan; and root canal therapy, if begun before the family member became covered under the Dental Plan.

MISCELLANEOUS SERVICES—Charges for implants and any prosthetic involved with implant, oral hygiene instructions, plaque control, sealants and dietary instructions are not covered.

SERVICES BY RELATIVES—Charges for dental care furnished by any person related by blood or marriage.

ORTHODONTIC SERVICES or DENTAL CARE of a congenital or development malformation.

DUPLICATE BENEFITS

HOW DO OTHER GROUP TYPE PLANS AFFECT BENEFITS?

If a person has dental coverage under another group plan we will coordinate our benefits with those of that plan. One plan is primary. One plan is secondary. The primary plan pays regular benefits in full. The secondary plan pays a

reduced amount which, when added to the benefits paid by the primary plan, will not exceed 100% of the total ALLOWABLE EXPENSES.

"ALLOWABLE EXPENSE" means the usual and customary charge for an item of care at least part of which is covered by one of the plans.

A plan that does not coordinate with other plans is always the primary plan. If both plans coordinate, the primary plan is determined as follows:

1. The plan which covers the patient as an employee, rather than as a dependent, is primary.

2. If both plans cover the patient as a dependent child, the following will determine which plan is primary:

   (a) The primary plan will be the plan of the parent whose birthday occurs earlier in the calendar year, except that:

   - If both parents have the same birthday, the primary plan will be the plan which has covered the parent for the longer period of time. "Birthday" refers only to the month and day in a calendar year, not the year in which the parent was born.

   - If either parent plan is issued in another state and does not have this rule for determining which plan is primary, but instead has a rule based upon the gender of the parent, the plan with the gender rule shall determine which plan is primary.

   (b) If the child's parents are separated or divorced, the primary plan will be the plan of the parent with custody of the child, except that:

   - If the parent with custody is covered as the spouse of the child's stepparent, the primary plan will be the plan of the stepparent.

   - If a court decree has said which parent has financial responsibility for the child's covered expenses, the primary plan will be the plan of the parent who has that responsibility if the insurer of that plan has actual knowledge of the terms of the decree. This does not apply to any claim determination period or plan year during which benefits are paid before the insurer had that actual knowledge.

3. If neither 1. nor 2. applies, the primary plan will be the plan which has covered the patient for the longer period of time, except that:

   (a) If the coverage of one plan is based on present employment, and the coverage of the other plan is based on prior employment, the primary plan will be the plan which is based on present employment; and

   (b) If either plan is issued in another state and does not have this rule for determining which plan is primary, this rule will not apply.

HOW DOES NO-FAULT AUTO INSURANCE AFFECT BENEFITS?

We will reduce the benefits we would normally pay due to injuries from an automobile accident, so that our benefits plus NO-FAULT BENEFITS do not exceed 100% of the covered expenses for such injuries.

"NO-FAULT BENEFITS" means the minimum level of personal injury benefits which state law requires to be offered under automobile insurance policies and which would be paid, regardless of fault, if claim had been made for such benefits.

EFFECT OF PRIOR PLAN COVERAGE WHEN YOU HAVE A CLAIM

SHOULD YOU KEEP RECORDS OF EXPENSES?

You should save all bills and receipts for dental expenses. We need them as proof of your claim.

MAY WE REQUIRE ADDITIONAL PROOF OF CLAIM?

Yes. Before paying benefits, we can require the following:

1. A dental chart showing work done before the treatment for which claim is made.

2. X-rays, lab or hospital records.

3. Cast molds or other evidence of the dental condition of treatment.

4. Post-treatment examination of the patient, at our expense, by a dentist we select.

WHEN COVERAGE ENDS

WHEN DOES YOUR COVERAGE END?
Your coverage will end on the last day of the Plan month during which any of the following events occur:

1. Your employment ceases; i.e. you cease active full-time work in the eligible classes;

2. You cease to be an eligible member of the Welfare Fund;

3. The Plan terminates.

WHEN DOES YOUR DEPENDENTS COVERAGE END?

Your dependents coverage will end on the earliest of the following events:

1. Your coverage ends;

2. The dependent ceases to be an eligible dependent;

3. The Plan is changed to terminate coverage for all dependents.

SURVIVOR BENEFIT COVERAGE

In the event of your death, your eligible surviving spouse and/or eligible dependent children's dental coverage will continue for six months from the date of your death with no cost to your survivors. However, coverage will cease immediately upon the following:

- your spouse remarries; or
- your spouse becomes insured for dental benefits from his/her employer; or
- the eligibility requirements are no longer met; or
- the date the policy terminates

Please Note: Upon termination of the six month Survivor Benefit coverage, your eligible dependents may continue coverage up to an additional 30 months under the COBRA Provision as outlined on page 25.

ARE BENEFITS PAID AFTER COVERAGE ENDS?

We will pay Dental Care benefits for the following Covered Expenses incurred by a covered member or eligible dependent within 30 days after coverage ends:

1. A denture for which an impression was taken before the covered member or eligible dependent coverage ended; and

2. A crown, bridge, or gold restoration for which preparation of the teeth was begun before the member's or eligible

dependents' coverage ended; and

3. Root canal therapy if begun before the employee's or eligible dependents' coverage ended.

COBRA - CONTINUATION OF COVERAGE

On April 7, 1986, a Federal law was enacted-Public Law 99-272, Title X - requiring that most employers sponsoring group dental plans offer employees and their families the opportunity for a temporary extension of dental/vision coverage - called continuation coverage.

If you are an employee covered by this dental/vision plan, you have a right to choose this continuation coverage if you lose your dental/vision coverage because of a reduction in your hours of employment or the termination of your employment, except for reasons of gross misconduct on your part.

If you are the spouse of an employee covered by this dental/vision plan, you have the right to choose continuation coverage for yourself if you lose coverage under this dental/vision plan for any of the following reasons:

(1) the death of your spouse;
(2) a termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
(3) divorce or legal separation from your spouse; or
(4) your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee covered by this dental/vision plan, he or she has the right to continuation coverage if the dental/vision coverage is lost for any of the following reasons:

(1) the death of a parent;
(2) the termination of a parent's employment (for reasons other than gross misconduct) or reduction in parent's hours of employment;
(3) parent's divorce or legal separation;
(4) a parent becomes eligible for Medicare; or
(5) the dependent ceases to be a dependent child under the dental plan

In the event of a Chapter 11 Bankruptcy, certain retirees and their dependents also have rights of continuation.

Under the law, the employee or a family member has 60 days to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the dental/vision plan.

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

When the plan administrator is notified that one of these events has happened, the plan administrator will in turn notify you that you have the right to choose continuation coverage.

Under the law, you have at least 60 days from the day you would lose coverage because of one of the events described above to inform your employer or the plan administrator (whichever is appropriate) that you want continuation coverage.

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

It is your responsibility to notify the Plan Administrator if you wish to continue coverage under COBRA.

If you choose continuation coverage, the Plan Administrator is required to offer you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost dental/vision coverage because of a termination of employment or reduction in hours.

In that case, the required continuation coverage period is 18 months. However, the law also provides that your

continuation coverage may be terminated for any of the following reasons:

(1) your former Plan Administrator no longer provides dental/vision coverage to any of its members;
(2) the premium for your continuation coverage is not paid;
(3) you become eligible for Medicare;

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

Continuance During Disability

A special continuation period applies to persons who are (a) entitled to the 18 month continuance referred to on page 24, and (b) certified as disabled under the Social Security Act before the COBRA 18 month continuation period ends. These individuals will be entitled to an additional 11 month continuation (total of 29 months continuation) if they provide notice of their disability within 60 days of a determination and prior to the expiration of the 18 month continuation period. The covered individual will be required to pay the monthly premium (not to exceed 150% of the full premium cost) during the additional 11 month period. This continuation ends if the individual is no longer disabled or when the additional 11 month have elapsed, whichever occurs first. The individual must notify the Plan Administrator within 30 days of a final determination that he or she is no longer disabled.

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)
as Federally Mandated

This rider is effective on the later of (a) the effective date of the policy; or (b) the date required by Federal law.

Family and Medical Leave

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

(a) to care for your child after the birth or placement of a child with you for adoption or foster care; as long as such leave is completed within 12 months after the birth or placement of the child;

(b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

(c) for your own serious health condition.

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

Conditions:

(a) If, on the day your Coverage is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Coverage for you and any eligible dependents will begin in accordance with the terms of the policy. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.

(b) You are eligible to continue coverage under FMLA if:

(1) you have worked for your employer for at least one year;
(2) you have worked at least 1,250 hours over the previous 12 months;

(3) your employer employs at least 50 employees within 75 miles from your worksite; and
(4) you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.

(c) In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the policy during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the policy. Any partially-satisfied waiting periods, including any limitations for a pre-existing condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

(d) You and your dependents are subject to all conditions and limitations of the plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

(e) If requested by us, you or your employer must submit proof acceptable to Claims Administrator that your leave is in accordance with FMLA.

(f) This FMLA condition is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the policy following the day your FMLA continuation ends:

(g) FMLA continuation ends on the earliest of:
(1) the day your return to work;
(2) the day you notify your employer that you are not returning to work;
(3) the day your coverage would otherwise end under the policy;
(4) the day your coverage has been continued for 12 weeks.

Important Notice:

Contact the Plan Administrator for additional information regarding FMLA.

It is the member's responsibility to notify CCTA Benefit Trust when any of the following occurs:

- your dependent child reaches the dependent age limit 19 or is no longer a full-time student.
- you become legally separated or divorced.
- you return from a leave of absence.

GENERAL PLAN INFORMATION

TYPES OF ADMINISTRATION

The Plan is a self-funded plan and the administration is provided through a third party Claims Administrator.

PLAN NAME

Cornwall Central Teachers Association Benefit Trust Fund

PLAN NUMBER: 501

TAX ID NUMBER: 14-1708264

PLAN EFFECTIVE DATE: July 1, 1988

PLAN YEAR ENDS: June 30th

EMPLOYER INFORMATION:

Cornwall Central School District
24 Idlewild Avenue
Cornwall-on-Hudson, NY 12520

PLAN ADMINISTRATOR/FIDUCIARY

Cornwall Central Teachers' Association Benefit Trust Fund
PO Box 719
Cornwall, NY 12518

CLAIMS ADMINISTRATOR

Fitzharris Administrators, Inc.
PO Box 9182
814 Fulton Street (Rte. 109)
Farmingdale, NY 11735-9181
516-777-2244/1-800-321-1336
FAX: 516-777-5777

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Cornwall Central Teachers Association Benefit Fund is the benefit plan of The Cornwall Central Teachers Association Benefit Trust, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. The Plan Administrator is appointed by and serves at its convenience. If the Plan Administrator resigns, dies or is otherwise removed from the position, The Cornwall Central Teachers Association Benefit Trust shall appoint a new Plan Administrator as soon as reasonably possible. If The Cornwall Central Teachers Association Benefit Trust does not appoint a Plan Administrator, The Cornwall Central Teachers Association Benefit Trust shall be deemed to be the Plan Administrator.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator shall have discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To decide dispute which may arise relative to a Plan Participant's rights.
3. To keep and maintain the Plan documents and all other records pertaining to the plan.
4. To appoint a Claims Administrator to pay claims.
5. To perform all necessary reporting as required by ERISA.

PLAN ADMINISTRATOR COMPENSATION. All expense for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill prudence and diligence under the given circumstances that a prudent person, acting in a like

capacity and familiar with such matters, would use in a similar situation;

2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Covered Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

THE TRUST AGREEMENT AND COLLECTIVE BARGAINING AGREEMENT

If this Plan is established under either a Trust agreement or a collective bargaining agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

1. A copy of the Trust agreement or collective bargaining agreement, as the case may be.

2. A complete list of employers and employee organizations sponsoring the Plan.

3. Information as to whether a particular employer or employee organization is a sponsor of the Plan. If the employer is a sponsor, then the address must be supplied.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
The Covered Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.
4. File suit in a federal court, if any materials requested are not received within 30 days of the Plan Participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $100 for each day's delay until the materials are received.

In addition to creating rights for Plan Participants. ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the Plan Participant requests materials from the Plan and does not receive them within 30 days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $100 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, that participant may file suit in state or federal court.

If it should happen that the Plan fiduciaries misuse the Plan' money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about his statement or his or her rights under ERISA, that Plan Participant should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

TO: Participants in health plans sponsored by Fitzharris & Company Inc.
FROM: Plan Administrator

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

Please note that the rest of this Notice uses the capitalized word, **"Plan"** to refer to each Health Plan sponsored by Cornwall Central Teachers Association Benefit Fund including any trustees who are responsible for handling health information maintained by the Health Plans as well as any service providers who handle health information under contract with the Health Plans. Health Plan means, for purposes of this notice, medical, dental, vision, and other coverages that meet the definition of Health Plan container in HIPAA.

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

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

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

Protected Health Information

This Notice applies to health information held by the Plan that includes identifying information about you (or your dependents). Such information, regardless of the form in which it is kept, is referred to in this Notice as **Protected Health Information** or **"PHI"**. For example, any health information that includes details such as your name, street address, a date of birth or social security number is PHI. However, information that does not include such obvious identifying details is also Protected Health Information if that information, under the circumstances, could reasonably be expected to allow the person who is reviewing that information to identify you as the subject of the information. Information that the Plan possesses that is not Protected Health Information is not covered by this Notice and such information may be used for any purpose that is consistent with applicable law and with the Plan's policies and requirements.

How the Plan Uses or Discloses Protected Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Disclosures to avert a serious threat to health or safety:** The Plan may, consistent with applicable law and standards of ethical conduct, use or disclose Protected Health Information, (1) if it believes the use or disclosure

is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (2) if it believes the disclosure is necessary for law enforcement authorities to identity or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to the victim or where it appears that the individual has escaped from a correctional institution or from lawful custody.

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

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

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

Uses and Disclosures Not Mentioned Above: Authorization Require

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

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

Your Health Information Rights

Under Federal Law, you have the following rights:

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

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

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

- **You may request that Protected Health Information Maintained by the Plan be amended:** If you feel that certain information maintained by the Plan is inaccurate or incomplete, you may request that the information be

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

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

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

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

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

Health Information Complaint Procedures

If you believe your health information privacy rights have been violated, you may file a complaint with the Plan. To file a complaint, you should contact Fitzharris' Privacy Department, P.O. Box 9182, Farmingdale, NY 11735. In addition to your right to file a complaint with the Plan, if you feel your privacy rights have been violated, you may file a complaint with the U.S. Department of Health & Human Services. You will never be retaliated against in any way as a result of any complaint that you file.