WARWICK VALLEY TEACHERS BENEFIT TRUST

ELIGIBILITY

The term "Participant" used in this descriptive booklet means:

A. A teacher or administrator who is employed 100 percent of the normal work day. Teachers or administrators who work less than 100 percent of the normal work day must contribute the difference in percentage of the part-time position in which he/she works to equal 100 percent.

B. The eligible Employee's lawful spouse.

C. The eligible Employee's dependents:

(1) Unmarried child who has attained the age of two weeks but has not attained the Age of 19 years and is a full time student.

(2) Unmarried child who is a full time student at an accredited institution of higher learning and has not attained the age of 25 years. Full-time student is defined as carrying at least 12 credits.

(3) Termination of coverage for post-secondary student not returning to school is 30 days from the last day of enrollment.

(4) Unmarried child who was (handicapped) before the age of nineteen years, and is dependent upon his parent or legal guardian for support. The Plan may require written proof of such dependence.

EFFECTIVE DATE OF COVERAGE

Coverage under this plan will begin on the first day of work. The one year waiting period on certain defined procedures is calculated from the date you are employed. Failure to enroll within 30 days of your eligibility will result in a 90 day waiting period from the date of application.

DENTAL PLAN

DESCRIPTION OF PLAN BENEFITS

The following benefits are payable, subject to the other provisions and limitations of the plan, for "Covered Dental Services."

A. Amount of Benefits

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

B. Maximum Benefits

Benefits payable to an eligible Participant and dependents in any plan year are limited to $2,000.00 per calendar year.

C. Deductible

As of 7/98 no deductible.

D. New members have a one year waiting period for the following:

1) Bridge and Crowns;
2) Orthodontia;
3) Periodontal (Osseous) Surgery;
4) Dentures

BENEFIT DETERMINATION

The Plan covers treatment performed while covered. Treatment will be considered to have been performed for the listed procedure as follows:

A. Dentures, full or partial – when impression is taken for appliance.

B. Fixed bridgework, crowns and gold restorations – when the tooth is first prepared.

C. Root canal therapy – when tooth is opened.

D. Orthodontics – when the first appliance is installed.

LIMITATIONS AND EXCLUSIONS APPLICABLE TO DENTAL BENEFITS PLAN

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

A. Unless such services, supplies or treatment were prescribed as necessary by a dentist or physician.

B. In a Veteran's Administration Hospital, or which in the absence of coverage, would have been furnished without cost, or are furnished under conditions where the Covered Individual has no legal obligations to pay or if the expenses are reimbursable by local or other governmental agency.

C. Covered under any group program or union, employer or association program to the extent that more than 100% recovery by the participant would be made for any charges for which benefits are provided hereunder.

D. Covered under the U.S, Social Security Act (Title XVIII) as amended from time to time.

E. If they were incurred on account of:

(1) war, declared or undeclared, including armed aggression;

(2) services, supplies or treatment received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group;

(3) loss or theft of dentures or bridgework;

(4) dentistry for cosmetic purposes, exclusive of orthodontia, including alteration or extraction and replacement of sound teeth for the purpose of changing appearance;

(5) bodily injury arising out of and in the course of employment by any employer, or disease or defect with respect to which benefits are payable under any Workmen's Compensation or Occupational disease Act or Law.

F. There are time restrictions indicated in the plan document for certain procedures. All members are expected to adhere to these time restrictions.

G. Crowning of teeth for periodontal support is not covered.

H. Temporary services are not covered expenses.

SUBMISSION OF PRE-TREATMENT ESTIMATES

A treatment plan, with respect to a course of services or treatment that is expected to exceed $300.00 in cost must be submit to the Plan within 20 days following the examination which reveals the need for such services or treatment. Such Treatment Plan MUST include appropriate x-rays, a description of services to be furnished, as well as an explanation of the need for such services or treatment. The Pre-Treatment estimate shall be submitted on official claim forms. With the exception of emergency work, failure to obtain **pre-approval** could result in non-payment of claim if need cannot be clearly established.

COVERED DENTAL SERVICES

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

A. Prepayment Treatment

(1) Cleaning of teeth (prophylaxis) is covered twice during each plan year. If a periodontal (04341 - 04340) scaling and a prophylaxis (01110) are performed on the same date, the plan will only pay for the scaling. Additionally, the plan will not cover a prophylaxis within 30 days of a full-mouth periodontal scaling.

(2) A fluoride treatment will be covered twice each plan year for children up to age 19.

(3) Space maintainers for children only.

B. Emergency Treatment

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

C. Diagnostic Services

The Plan covers oral examinations, X-rays and laboratory tests that may be necessary to diagnose a specific symptom.

The Plan will cover no more than four (4) x-rays for any one oral examination. However, a full mouth x-ray of all teeth taken as part of a general examination is covered once in a three year period. Allowances for films or other procedures covered by the Plan include the charge for examination and diagnosis. Oral exams are covered twice per plan year.

D. Anesthetics

A separate charge for general anesthesia is only covered in conjunction with partial and full bone extraction, osseous surgery, fractures or dislocation. A charge for local anesthesia is not covered as it is included within the normal charge for the treatment for which the local is given.

E. Drugs

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

F. Extractions and Oral Surgery

The Plan covers all extractions and/or other necessary oral surgery including fractures and dislocations. Allowances for extractions and oral surgery procedures include routine post-operative care. The Plan covers oral surgery related to the excision of tumors and/or cysts which are located on the teeth, gum tissue and the alveolus surrounding the teeth. Claims for extraction of wisdom teeth must be accompanied by X-rays of the area in question.

G. Fillings

The Plan covers fillings that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury. This includes all silver (amalgam) and composite fillings. Fillings involving the same surfaces are not covered within two (2) years of date of service. **The plan will not waive time restriction for any reason.**

H. Crown/Onlays and Inlays

Crowns that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury and cannot be reconstructed by a filling or other material are covered. This includes gold, porcelain and plastic restorations. Gold onlays and inlays are also covered if the tooth cannot be reconstructed by a filling of other material. Crowning of teeth for periodontal support is not covered. Replacement crowns and onlays are not covered within five (5) years of prior placement. **The plan will not waive time restriction for any reason.**

NOTE: New members are not covered for one year for crowns.

I. Treatment of Gum Diseases - Periodontics

The Plan covers necessary periodontic treatment of the ums and supporting structure of the teeth. The plan will pay for two (2) periodontal scalings per year. Periodontal maintenance and perio-prophy will be counted as preventive care, which is covered twice

per year. The Plan will only pay for periodontic maintenance (04910) where the individual has been involved with procedures of periodontal curettage or osseous surgery. (See Preventive Treatment page 4.)

In the event that the plan is billed for full-mouth periodontal scaling, full-mouth periodontal curettage and full-mouth periodontal osseous surgery, the plan will not pay for periodontal curettage.

Major periodontal work must be pre-approved with supporting x-rays and charting. Osseous surgery will not be covered within five (5) years of the last treatment. **The plan will not waive time restrictions for any reason.**

NOTE: The members are not covered for perio-surgery for one year.

J. Root Canal Therapy

The plan covers root canal and other endodontic treatment. All services provided that are normally associated with root canal therapy are included in the scheduled fee.

K. Orthodontics

There is a maximum life-time orthodontic benefit of $2,000.00.

Benefits will be paid at 100% of fee charged up to the $2,000.00 lifetime maximum for appliance placement and active monthly treatment.

Adult orthodontia cases are not covered.

Payment will be made for active monthly treatment only. Retainers are considered part of the total treatment plan, and therefore are not a separate expense.

NOTE: New members are not covered for orthodontics for one year.

If a new member's dependent child is already in orthodontic treatment on the date they become eligible for orthodontic coverage the following formula will apply. Twenty-four (24) months will be considered a full case. The plan will subtract the number of months already in treatment from 24 and pay the maintenance allowance for the remaining months.

L. Prosthetics

The Plan covers prosthetic appliances (full denture, partial removable or fixed bridgework). The Plan will not cover the initial placement of appliances involving teeth extracted prior to coverage. However, the Plan will cover dentures or fixed bridges

that replace an existing appliance even if the teeth are not extracted while covered, if the prior appliance is more than five (5) years old and cannot be made satisfactory. Where teeth are being replaced within the same arch, but not within the same quadrant, an allowance for a partial will be made and not for fixed bridgework. The Plan also includes benefits for repairing damaged dentures or adding teeth to existing dentures or rebasing the denture. If the Plan pays for a new denture, it will not also cover the repair or rebasing of an old denture. Relines are not covered within the first six (6) months from the date of placement, and are not covered more often than once per plan year. The Plan does not cover precision or semi-precision attachments. The plan will not cover replacement of prosthetic appliances in less than five (5) years for any reason. **The plan will not waive time restrictions for any reason.**

NOTE: New members are not covered for dentures and bridgework for one year.

M. Implants

Implants which are not of an experimental nature are considered a covered service.

DEFINITIONS

A. Dentist - The term "dentist" shall be deemed to mean a Doctor of Dental Surgery or Doctor of Medical Dentistry.

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

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

D. PLAN YEAR - January 1 - December 31.

HOW TO FILE A CLAIM

Step 1 - Request the official claim form from your trustees.

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

Step 3 - Have your Dentist complete his portion of the claim form.

Step 4 - Send to:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
1-(800) 573-7474

NOTE: SEND ALL CLAIM FORMS PROMPTLY. CLAIM FORMS MUST BE FULLY COMPLETED BY ALL PARTIES CALLED FOR AND SUBMITTED WITHIN 90 DAYS FROM THE CLOSE OF THE PLAN YEAR. IMPROPERLY COMPLETED FORMS WILL CAUSE A DELAY IN THE PAYMENT OF A CLAIM.

Proper consideration can only be given to a claim when the completed form is received.

All claim inquiries should be directed to Preferred Group Plans. Office hours are Monday through Friday, 8:00 a.m. to 4:30 p.m.

COMMON CLAIM PROBLEMS

A. Incomplete information regarding whether you or your spouse has other group insurance coverage, and if so name or group, name of insurance company, address, policy number, etc.

B. Incomplete information regarding dates of birth or age.

CLAIM PROCESSING

Examination - The Trust, at its own expense, shall have the right and opportunity to examine any member as often as it may reasonably require during the review and processing of the claim.

VISION BENEFIT PROGRAM

COVERED SERVICES

Eye Examination - check of principal visual functions, ability and condition of vision. A medical diagnosis should be filed with your medical carrier.

Glasses are covered if a visual deficiency exits.

EXAMINATIONS & GLASSES

The Plan will allow a maximum benefit per individual to be used for an eye examination and glasses or contacts. **Please see the Schedule of Benefits for this maximum amount.**

The Plan will only pay amounts up to the actual charge and is not responsible for charges in excess of the schedule.

BENEFIT PERIOD

Eye examinations and glasses are covered **every other plan year.** The Plan will pay for glasses or contacts but not both.

LASIK SURGERY

The plan allows a $500.00 per eye benefit for lasik surgery. If you use this benefit you will not be eligible for vision benefits for five years. **This is an employee only benefit and the employee must have at least 3 years of continuous service.**

HOW TO RECEIVE THE VISION ALLOWANCE

1. Vision claim forms can be obtained from the Trustees or a location established by the Trustees.

2. Complete all sections of the form that relate to member information. Have the doctor complete his/her portion of the form. Send this form to our claims administrator:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
1-(800) 573-7474

LIMITATIONS

If during the Benefit Period a change of .50 diopters or greater in prescription for one or both eyes is determined to be necessary, the plan will reimburse the scheduled allowance for such eye exam and lenses, and up to the scheduled allowance for the cost of frames if such change in frames is necessary due to change in lenses, and up to the scheduled allowance for contact

lenses. (Please note that the Plan provides reimbursement for either contact lenses or glasses, but not both.)

PRESCRIPTION COVERAGE/MEDICAL CO-PAY

Covered: A Total Plan year benefit of $175.00 for any expenses not covered by insurance. Claim forms can be obtained from the Trustees or a location established by the Trustees.

HEARING AID BENEFIT (7/1/2014)

Covered: Employees eligible three or more years in Warwick Valley Central School District Benefit Trust. A family benefit of $200 over a two year plan year period for hearing aid expenses not covered by any other plan.

DEATH BENEFIT

Covered: Employee only - a payment of $2,000.00 will be made to an Employee's estate upon the death of said employee.

Coverage is canceled upon retirement or separation of employment

TERMINATION OF COVERAGE

Coverage will end on the earliest of the following events:

(1) Your employment ceases;

(2) You cease to be an eligible member or dependent;

(3) You stop making any payments required for your coverage; or

(4) The plan terminates.

LEAVE OF ABSENCE

Any member of the Trust granted a leave of absence by the Board of Education after at least one year of continuous membership in the Trust, may maintain his/her membership through direct personal payment to the Trust. Payment will be required in full within 30 days of last day worked, and will be equal to the amount that would have been due from the Board of Education. In the event payment is not received within 30 days, membership will be terminated. If membership is not maintained the member, upon return, will be subject to all rules effecting new members. The Trust will carry a teacher on leave for a maximum of two years.

COBRA - EXTENSION BENEFITS

Under the Consolidated Omnibus Reconciliation of 1985 (COBRA) certain individuals are given the option of continuing their group health benefits under specified conditions.

You and your dependents are eligible to continue coverage for up to 18 months when termination is due to a reduction in your hours worked, or upon termination of your employment.

A member who (a) elects to continuation coverage as the result of termination of employment and (b) is subsequently determined by Social security to have been disabled as of the date of termination, is entitled to continue coverage for 29 months instead of 18 months.

Your dependents are eligible to continue their coverage for up to 36 months upon the occurrence of the following events.

(a) The spouse and children upon the death of the covered employee.

(b) The spouse, upon divorce or legal separation from the employee.

(c) The spouse and children of Medicare-eligible employees, when the employee ceases to participate in the plan.

(d) Dependent children when they cease to be a dependent child under the definition in the plan.

Coverage cannot be continued beyond any of the following dates.

(a) The date on which the Trust ceases to provide any plan to any member.

(b) The date the premium is not paid by the individual.

(c) When the individual becomes covered by any other group health plan, except if the other group health plan contains a pre-existing condition limitation that applies to the person receiving continuation coverage, or when the individual is entitled to Medicare benefits.

(d) In the case of a spouse, when the spouse remarries and becomes covered under another group health plan, except if the other group health plan contains a pre-existing condition limitation that applies to the person receiving continuation coverage.

If your coverage terminates, or is about to terminate, you will be provided with a Continuation of Coverage Election Form which will enable you and your spouse to elect or reject continuation of group health coverage. You are responsible for providing us with current information as to your family status (i.e. separation, divorce, or dependent ineligibility for coverage.)

Your election to continue coverage must be completed within 60 days after you receive this Continuation of Coverage Election Form, or your termination date, whichever occurs last. Benefits provided shall be identical to coverage provided for active full-time employees and their dependents who have coverage under the plan but have not yet terminated their coverage. The cost to continue coverage is paid for by the individual. Within 180 days before the expiration of your continuation of coverage, you shall have a right to convert to a conversion policy if such a

policy is part of the group health plan at the time of your termination and is being offered to other active full-time employees under the plan.

For a complete description of COBRA and questions regarding your right to continue coverage after your termination date, please contact your Trustees or Plan Administrator.

EXTENDED BENEFITS PROVISION

If a participant's eligibility for coverage under this Plan terminates, benefits are available for up to thirty (30) days following termination of eligibility but only to cover those dental services pre-approved before the termination date. All charges filed for will be applied to the plan year maximum of the year termination took place.

COORDINATION OF BENEFITS PROVISION

Some individuals have coverage in addition to the benefits provided by this. When this happens, the amount of benefits payable under this plan will take into account any coverage a Participant has under "other plans" so the combined benefits under this Plan and "other plans" will not exceed the total expenses involved. For purposes of coordinating benefits of multiple coverage, an "other plan:" means any plan of benefits provided by:

A. group insurance or any other arrangement of coverage for individuals in group which provides benefits or services on an insured or an uninsured basis;

B. "no fault" automobile insurance which is required under any law and is provided on other than a group basis; or

C. Plans provided by the U.S. Government, State Government or any instrumentalities thereof.

In coordinating the benefits for a Participant having multiple coverage, the "primary" plan pays first and the "secondary" plan pays next to make up the difference, but the total benefit paid by both the primary and the secondary plans will not exceed 100% of the allowable expenses incurred. In addition, no plan will pay more benefits than it would normally provide without this special coordinating provision. In determining which plan is primary and which plan is secondary, the following order will be used:

A. A plan without a coordination of benefits provision will always be the primary plan; and

B. If all plans have a coordination of benefits provision then:

(1) The plan covering the Participant as an Employee is primary;

(2) The plan covering the Participant as a dependent Spouse is secondary;

(3) With respect to Dependent Children, the plan that covers a person as a dependent of an employee whose month and day of birth occur earlier in the calendar year will be considered primary.

****** WHEN SUBMITTING CLAIMS FOR MEMBERS OF THE FAMILY WHO ARE PRIMARY THROUGH ANOTHER CARRIER AND SECONDARY TO THE PARTICIPANT'S PLAN, A COPY OF THE PRIMARY PLAN'S PAYMENT MUST ACCOMPANY THE CLAIM.**

GENERAL INFORMATION CONCERNING PLAN COVERAGE

The benefits provided by this Plan are for reimbursement of incurred expenses, and payment by the Plan will be made only for those costs actually incurred and paid for by the eligible Participant. Reimbursement will not be made for any amounts for which the Participant is not legally liable in the absence of coverage by this Plan.

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

PRE-CERTIFICATION/APPEALS

In the event a part or all of a claim is denied due to the enforcement of the Plan document, you may appeal to the Trustees. If an appeal is not made prior to the work being completed on a pre-certified claim, the appeal will not be honored. All appeals must be in writing and directed to our plan administrator. Please provide all information needed to support your appeal. The letter should be sent to our administrator so that is can be presented at the next scheduled meeting of the Trust. Appeals must be received no later than 60 days after you receive the determination in question.

RIGHT OF RECOVERY

A. Whenever we have made payments for Covered Services in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, irrespective of to whom paid, we have the right to recover the excess payment from one or more of the following: any person to or for whom such payments were made, any insurance companies or any other organization.

B. You, personally and on behalf of your Enrolled Family Members will, upon request, execute and deliver such documents as may be required and to recover excess payments. Your failure to comply will result in a withdrawal of benefits already provided or a denial of benefits requested.

APPENDIX

Standards for Privacy of Individual Identifiable Health Information (the "Privacy Standards")
issued pursuant to
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Preferred Group (PG) Notice of Privacy Practices

HIPAA Provisions

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan. (See the Article entitled "General Information About Our Plan" for the definition of Plan Sponsor.)

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards)

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI

(c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards

(d) Report to the Plan any PHI use or disclosure that is inconstant with the uses or disclosures provided for of which the Plan Sponsor becomes aware

(e) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524)

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526)

(g) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528)

(h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of

Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*

(i) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible

(j) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Human Resources Manager
Staff designated by Human Resources Manager
Chief Financial Officer
Plan Auditor
Plan Administrator
Third Party Administrator

ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Plan Administration activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. Plan Administration functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans. The plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan

Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 FR164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with Privacy Standards.

The Preferred Group (PG) Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At PG, we believe in keeping your protected health information (PHI) safe. PHI includes information that we have created or received about your past, present, or future health or medical condition that could be used to identify you. It includes information about medical treatment you have received and about payment for health care you have received. PG keeps protected health information in strict confidence. As part of providing services, we may get information from the following sources: application forms, claims, and other information provided to us. This information can be given to us in writing, in person, by telephone, or by any other means. This information may include name, address, and employment information. We do not share, sell, or rent any protected health information about our current or former members.

PG restricts access to information to those PG employees who need to know that information to provide services. We also maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your information.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures PG will make of your protected health information. This notice takes effect on April 14, 2003. PG reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. If we make significant changes to the privacy practices on this notice, we will send a new Notice of Privacy Practices to all plan participants within 60 days. You can always request a copy of our most current privacy notice from our office or you can access it on our Web site at www.thepreferredgroup.com.

Permitted Uses and Disclosures

PG can use or disclose your protected health information for purposes of treatment, payment and health care operations. Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used. When the plan receives a bill from you or the provider, PG can obtain information regarding your care, if necessary, to provide payment. Health care operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, provider reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of providers used in our plan. We may also combine medical information about many patients to decide how to better provide needed benefits under the plan.

Other Uses and Disclosures of Protected Health Information
PG may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you. PG may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. PG will only disclose the protected health information directly relevant to their involvement in your care or payment. PG may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, or payment for that care. If you are available, PG will give you an opportunity to object to these disclosures, and the plan will not make these disclosures if you object. If you are not available, PG will determine whether a disclosure to your family or friends is in your best interest, and the plan will disclose only the protected health information that is directly relevant to their involvement in your care or payment for that care.

Except for the situations set forth below, PG will not use or disclose your protected health information for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing except to the extent that PG already has taken action in reliance on your authorization.

Exceptional Situations
We may use or disclose your protected health information in the following situations without your authorization:

We may release medical information to: a coroner or medical examiner (for example, to identify a deceased person); federal or state agencies that oversee our activities (to monitor the health care system, government programs, and compliance with other laws.); to a correctional institution or a law enforcement official (to protect your health and safety or the health and safety of others); to a law enforcement official (in response to a court order, subpoena, warrant, summons or similar process); to a court (in response to a subpoena, discovery request, or other lawful process); to military command authorities (if you are a member of the armed forces); to authorized federal officials for intelligence or other national security activities; to an organ donation organization (to facilitate organ or tissue donation and transplantation); to authorized federal officials (to provide protection to the President or other authorized persons); to public health agencies (to prevent or control disease, injury or disability); to appropriate agencies (to prevent or lessen a serious and imminent threat to the health or safety of a person or the public) and to programs that provide benefits for work-related injuries or illness.

Your Rights
- You have the right to request restrictions on PG's uses and disclosures of protected health information for treatment, payment and health care operations. However, PG is not required to agree to your request.
- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations. (*Use: Alternate Means of Communication Request Form*)

- Subject to payment of a reasonable copying charge (if you cannot afford to pay for copies, you will not be denied access), you have the right to inspect and copy the protected health information contained in the plan's records, except for psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. (*Use: Inspection and Copying Request Form*)
- You have the right to request a correction to your protected health information, but PG may deny your request for correction. Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records. (*Use: Amendment of Health Information Form*)
- You have the right to get a list of situations in which we have given out your PHI. The list will not include:
  a) disclosures we made so you could get treatment; b) disclosures we made so we could make payment for your treatment; c) disclosures we made in order to operate our business; d) disclosures made directly to you or to people you choose; e) disclosures made to corrections or law enforcement personnel; f) disclosures we made before we sent you this notice; or g) disclosures we made when we had your authorization. We will respond within 60 days of getting your written request for the list. The list we give you can only include disclosures made after April 14, 2003, the date this notice becomes effective. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. (*Use: Accounting of Disclosures Request Form*)
- You have the right to request and receive a paper copy of this notice from us.

Filing a Complaint
If you believe that your privacy rights have been violated, you should immediately contact Melanie B. Hiller at 800-573-7474 . PG will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Contact Person If you have any questions or would like further information about this notice, please contact Arlene J. Tamasi at 800-573-7474. This notice is effective as of April 14, 2003.