

# MEMBER BENEFITS GUIDE

**MAMARONECK TEACHERS' ASSOCIATION TRUST FUND**

DENTAL / VISION / RETIREE PROGRAM /  
LEGAL SERVICES / COBRA

2025-2026



**DANIEL H. COOK**  
ASSOCIATES INC

1040 Avenue of the Americas, 24<sup>th</sup> Floor, New York, NY 10018

# MAMARONECK TEACHERS' ASSOCIATION BENEFIT INFORMATION

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Your plan year is from **July 1 to June 30**. The mailing address is:

Mamaroneck Teachers' Association Trust Fund  
1040 Avenue of the Americas, 24<sup>th</sup> Floor  
New York, NY 10018

All claims must be submitted within 90 days of the close of your plan year (by September 30).

## A NOTE ABOUT THIS GUIDE

This guide describes the main features of the plan but is for **SUMMARY purposes only**. 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.

## AM I ELIGIBLE?

### Participants

The term "participant" used in this member guide means:

- A. Any employee for whom contributions are made to the Mamaroneck Teachers' Association pursuant to any collective bargaining agreement, individual contract of employment or School Board policy.
- B. The eligible employee's lawful spouse (see "Dependents" below).
- C. The eligible employees dependents (see "Dependents" below).
- D. A Retiree

**Please Note:** New members have limited benefits during the first Plan Year of participation in the welfare fund.



**RETIREE:** Retirees have three options: 1) retirement plan, 2) COBRA, or 3) not continuing in benefits. Upon retirement, you must enroll in the self-pay retirement plan or COBRA to continue coverage. Retirement coverage is on a direct pay basis.

### Dependents

The following dependents are eligible for coverage:

- o Legal spouse.
- o Qualified domestic partner (if they are approved and covered under the medical plan)
- o Unmarried child who has attained the age of two weeks but has not attained the age of 19 years.
- o **Effective 1/1/2026: Dependent coverage extended to all unmarried children until the limiting age of 26, regardless of full-time student status.** Unmarried child who is a full time student at an accredited institution of higher learning and has not attained the age of 26 years. Full-time student is defined as carrying at least 12 credits.
  - o Termination of coverage for a post-secondary student not returning to school is 30 days from the last day of enrollment.
- o 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.

- The eligible Retiree's spouse or covered dependent child.

In the event of the death of an active who has family coverage under the plan at the time of his/her death, the employee's surviving spouse, and any dependent children, may continue to participate in the plan on the same basis as an active employee as long as the surviving spouse satisfies the payment requirement which would be the same as that of a Retiree.

## Mentally or Physically Handicapped Children

If a Covered Dependent child:

- Reaches the age at which he/she would otherwise cease to be a Covered Dependent,
- but is mentally or physically incapable of earning their own living;
- and is primarily dependent upon you for support;
- And you submit satisfactory proof of the child's incapacity.

Then coverage may continue for such child for as long as he or she remains incapacitated, subject to payment of an applicable required contribution and all other terms of the Plan.

## Retirees

As a Mamaroneck retiree you may choose to continue your dental and vision benefits on a **self-pay basis**. Please see the Retiree section for more information.

## HOW DO I ENROLL?

You enroll for coverage by completing the enrollment form given to eligible employees at the time of hire and submitting them to your MTA benefits office. If you wish to cover any eligible dependent, you must elect coverage for all your eligible dependents.

If you have any status changes such as marriage, divorce, new baby, name change, new address, etc., please complete the Daniel H. Cook Associates enrollment/change form and submit them to **MaryAnn Lanza** in your MTA benefits office.

**Office Location:** MTA office - MHS, Rm. N-101

## Adding Dependents

**Active Members:** Active Members can enroll dependents at any time during the Plan year. Coverage will commence at the start of the Plan year, except for the 2025-2026 Plan year when coverage will commence on January 1, 2026.

**Retirees:** Retiree participants may elect family coverage upon initial enrollment upon retirement, upon reenrollment as a retiree participant, and upon a qualifying event. Coverage will commence at the start of the plan year, except for the 2025-2026 plan year, coverage will activate January 1, 2026 for newly added dependents.

## WHO IS ADMINISTERING MY BENEFITS?

The benefits of Mamaroneck Teachers' Association are now being administered by Daniel H. Cook Associates, Inc. We have been trusted third-party administrators for over 45 years, founded in 1977, and have built a strong reputation for putting our clients' needs first.

All of us at Daniel H. Cook Associates, Inc. thank you for the opportunity to serve you and your Trust!

## EFFECTIVE DATE OF COVERAGE

All full-time teachers and administrators are eligible to participate in each and every benefit provided through the Benefit Trust Fund. It is the responsibility of each eligible employee to apply for membership in the various plans at the stated times, and to follow all the eligibility requirements as they are set forth in the handbooks or publications issued by the Trust.

## 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.

## CLAIMS

When you have a claim, you should promptly submit the completed claim form and bills or receipts. Claim forms must be fully completed by all parties (provider and member) and filed within 90 days from the close of the plan year. The plan year is July 1 to June 30. Claims must be received at the claim office no later than September 30.

If you have primary coverage through another benefit plan, and your coverage under the Mamaroneck Teachers Trust is secondary, file your claim with the Mamaroneck Teachers Trust Administrator before the end of the 90-day period after the close of the plan year, even though your primary coverage provider has not coordinated your benefits. This will ensure that your claim is not denied as being untimely.

**Please note: Benefit checks may have an expiration date. Please cash promptly.**

## HIPAA PRIVACY NOTICE

The Plan shall disclose Protected Health Information (PHI) only to members of the Trust's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. The Trust may use or disclose PHI for operations such as auditing, quality improvement, premium or contribution calculations, and managing the plan. Additionally, the Trust may use or disclose PHI to coordinate your health care services with providers, such as doctors, pharmacies, or hospitals.

The Trust has implemented reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Trust creates, maintains, or transmits on behalf of the Plan. "Electronic Protected Health Information" refers to all Protected Health Information that is transmitted by or maintained in electronic media.

The Trust will never use your PHI for:

- Marketing Purposes
- Sale of your PHI, or
- Fundraising Communications

without your explicit written permission.

## COBRA – CONTINUING/EXTENDING BENEFITS

Under the Consolidated Omnibus Reconciliation Act 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 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 (dental and vision benefits are not covered by Medicare.)
- 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 preexisting 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 preexisting 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 dental/vision 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.

## NEW MEMBERS

New members have **time restrictions that apply to certain procedures** – please see the Dental section for more information and the “Covered Dental Services” section of your Trust’s plan booklet. New members have an annual dental maximum equal to the district contribution available during their first Plan year of eligibility.

## RETIREE PROGRAM

**Annual Fee:** The annual cost to continue in Retiree benefits is determined annually by the MTA Trustees. The fee is equal to the dollar amount that the board contributes to the MTA Welfare Trust Fund divided by the number of eligible MTA members who are presently active educators.

### Requirements:

1. Retirees must be fully retired and eligible to draw a New York State Retirement System pension.
2. Retirees must elect to participate in the program by June 15 of their final year of teaching and must pay the first year premium by that date. (Submit check payable to the MTA.)
3. Notices of succeeding years premiums will be sent out by June 1<sup>st</sup> by certified mail, return receipt requested, and payment for the following year of coverage must be made by check payable to the MTA by July 1<sup>st</sup> of the same year.
4. Any member participating in the program who does not make the “timed” payment will have his/her coverage terminated **and will not be eligible again for coverage or participation in the plan.**
5. Members who do not elect to join the plan in their final year of teaching will not be allowed to participate in the plan.
6. This plan will be available to teachers retiring as of 6/30/85. Teachers who have previously retired are not eligible.
7. The Trustees, at their sole discretion, may terminate this plan. Retirees will be notified by certified letter of any cancellation. Under no circumstances will the Trustees terminate the plan during a fiscal year – said termination would be effective July 1st.
8. The Trustees, at their sole discretion, have the right to alter the plan in any way including, but not limited to, payments, fees, benefits, limits and restrictions. Retirees would be notified of any changes by certified mail, sent out June 1st, so they may determine if they wish to continue in the plan.

9. There will be no refunds (full or partial) for payments made any given year.
10. In the event of the death of a Retiree who is covered under the plan as a Retiree on the date of his/her death, the retiree's surviving spouse, and any dependent children, may continue to participate in the plan on the same basis as a Retiree as long as the surviving spouse continues to satisfy the payment requirements of the Retiree program.

## DENTAL PLAN OVERVIEW



*Please note: Your ANTHEM plan/network name is: "DENTAL PPO ACCESS."  
You should submit a pre-treatment estimate for any claim that is expected to exceed \$700 in cost.*

### Dental Plan

This guide is providing a **summary only**. For in-depth rules about covered services, please refer to your Trust Plan Document.

The following is an overview of the dental plan available to members:

Benefits	Description
Annual Individual/Family Maximum Benefit	\$2,000.00 Per Covered Individual \$4,000.00 Per Family
Annual New Employee Maximum Benefit	New members have an annual dental maximum equal to the district contribution available during their first year of eligibility.
Orthodontia Lifetime Maximum Benefit	\$3,000.00 Max Lifetime per Individual
Payment Percentage	100% of the allowable charge
Coverage Notes	Coverage for dependents between the ages of 19 and 26 follows the parameters for adults
Limitations at-a-Glance	<p>Each covered member is entitled to:</p> <ul style="list-style-type: none"> <li>• 3 Cleanings or Periodontal Maintenance per Plan Year*</li> <li>• 2 Oral Exams per Plan Year</li> <li>• 2 Periodontal Scalings per year</li> <li>• 4 Bitewing and other X-rays as a part of a routine exam per Plan year</li> <li>• 1 Full Mouth X-Ray every 3 years.</li> <li>• 2 Fluorides per Plan Year to age 19</li> <li>• 2 Emergency Dental Treatments per Plan Year</li> <li>• Space maintainers and their fitting, limited to children under age 19.</li> </ul> <p>* 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-month periodontal scaling.</p>



*Your ID Card with your Dental ID Number will be provided to you after enrollment from DHC. You do not require an ID Card for vision services. All covered individuals under your plan will have a different ID number.*

### Benefit Determination

The Plan will pay a Covered Expense up to the allowable charge for preventive, diagnostic, fillings, prosthetic, restorative, and orthodontic services.

## Predetermination of Benefits

A treatment plan, with respect to a course of services or treatment, that is expected to exceed \$700.00 in cost must be submitted 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.

**When sending in Predetermination of Benefits for charges expected over \$700, follow the steps below before starting a dental treatment.**

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Member and Patient section(s) of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Daniel H. Cook Associates, Inc.  
1040 Avenue of the Americas, 24<sup>th</sup> Floor  
New York, NY 10018

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays, and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services, or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

**Please Note:** A pre-determination does not guarantee benefits unless you are eligible for benefits when the services are rendered. Also, benefits are subject to the allowable charges and maximums. Also, with the exception of emergency work, failure to obtain pre-approval could result in non-payment of the claim if need cannot be clearly established.

## Common Claim Problems

- 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.
- If there is other group coverage, send a copy of the benefit payment record furnished by the other plan.
- Incomplete information regarding dates of birth or age.

## Anthem's Dental PPO Network

The Providers have agreed to accept the fee schedule as payment in full; they will submit the bills directly to us and we will pay them directly. If you choose a non-participating dentist you will be responsible for any amount

billed over the plan amount for the services provided. If a provider would like to join the network they can contact the plan to request and accept the fee schedule.

### Coordination of Benefits

If you and your spouse each have coverage, your dependent children will be considered primary by the plan of the person whose month and day of birth occur earlier in the calendar year.

When you submit claims for members of the family who are primary through another carrier, a copy of the primary plan's payment must accompany the claim.

### Submitting a Claim for Reimbursement

When visiting an out-of-network provider, you may sometimes be required to pay upfront. In such an event, you can submit the claim form for your services directly to DHC for reimbursement. At the bottom of the claim form, please be mindful to only sign the appropriate authorization to send the reimbursement to you, the member, directly and not the provider.

AUTHORIZATIONS	
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.	
<input checked="" type="checkbox"/> Patient/Guardian signature	Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.	
<input checked="" type="checkbox"/> <del>Subscriber signature</del>	Date

1.

# HOW TO FIND A DENTAL PROVIDER ONLINE

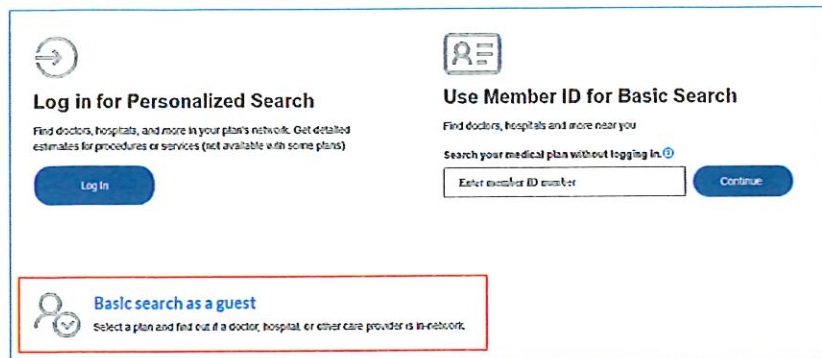


 **Your dental coverage is through Anthem Empire BlueCross Blue Shield. Please use the instructions below to find a dentist online. Your plan/network name is: "DENTAL PPO ACCESS" – please ensure the network name is correct to have a successful search.**

## STEP ONE

Visit [www.wellpoint.com/find-care/](http://www.wellpoint.com/find-care/) (or visit wellpoint.com and then click "Find Care")

- Click on "Basic search as a guest"



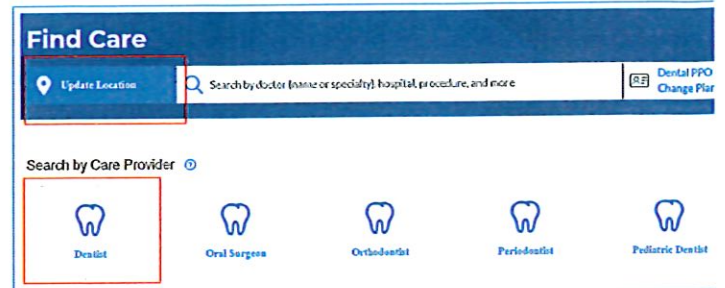
## STEP TWO

When searching as a guest, complete the following fields:

- Select the type of plan or network.
  - Select **Dental Plan or Network**
- Select the state where the plan or network is offered.
  - Select **New York** (this will not limit out-of-state searches)
- Select how you get health insurance.
  - Select **Dental**
- Select a plan or network
  - Select **PPO Access**

## STEP THREE

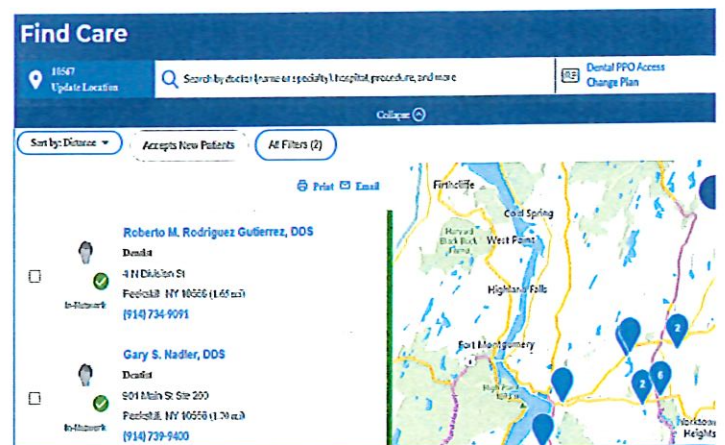
Update your zip code/location and then click on the type of Dental Provider you are searching for.



## STEP FOUR

View your search results.

- Use the icons on the right-hand side to automatically download your search list to PDF for easy printing and emailing of your search results.
- You can continue to filter your search results using the options on the left-hand side (Can select "Accepting New Patients," and can adjust distance, etc.)



## Basic search as a guest

Select the type of plan or network

Care Providers for Behavioral Health & Substance Use Disorder Services are listed under Medical plan or network.

Select the state where the plan or network is offered. (For employer-sponsored plans, select the state where your employer's plan is contracted in. Most of the time, it's where the headquarters is located.)

Select how you get health insurance

Select a plan or network

## VISION PLAN OVERVIEW



*The Plan will only pay amounts up to the actual charge and is not responsible for charges in excess of the schedule. Services are offered through the DAVIS VISION program.*

### Vision Plan

The following is an overview of the vision plan available to members:

Benefits	Description
Benefit Overview	Eye examinations and glasses are covered <b>once per covered individual per plan year.</b>
Payment Type	Reimbursement
Payment Percentage	100% of the allowable charge
Annual Maximum per Plan Year	If you use your own eye doctor, you will be reimbursed a maximum of \$120 per individual for these services.

### Covered Services

1. **Eye Examination:** Check of principal visual functions, ability, and condition of vision. If a medical diagnosis exists, the claim should be filled with your medical carrier.
2. **Glasses/Contacts:** choice of one annually, not both.
3. **Sunglasses:** Only prescription sunglasses are covered.

**Please note:** Services or supplies beyond which are listed may require having to pay the provider the difference. Vision vouchers are not necessary.

## Davis Vision Program and Participating Vision Providers

Vision services are offered through the Davis Vision Program. By using utilizing the participating providers, you and your eligible dependents will be able to receive a vision examination and glasses (from a selection) with no out-of-pocket expense. The program offers a selection of frames and lenses from which you may choose.

**Please note:** If you decide not to use frames and lenses offered through the program, you will have to pay the optometrist's charge for the frames and lenses you choose.

A list of optometrists participating in the program is available on the Davis Vision website.

You can contact Davis Vision by phone: Telephone: (800) 999-5434. **Vision claim forms can be found on their website: [davisvision.com](http://davisvision.com)**

You may also use Raymond Opticians at any of their locations or Larchmont Vision Care. If you use Raymond Opticians or Larchmont Vision Care, identify yourself as having vision coverage through Mamaroneck Teachers' Association Trust Fund.

### How-to File a Vision Claim

If you are using a participant provider, the optometrist will file the claim on your behalf and will be paid directly by the claims administrator. Please remember to identify yourself as having vision coverage through Mamaroneck Teachers' Association Trust Fund.

If you use your own optometrist, outside of the participating providers, please fill out a vision claim form with Davis Vision regardless – they will submit it for processing.

## VIEWING YOUR CLAIMS ON DHCLAIMS.COM



### STEP ONE

Type in [www.dhclaims.com](http://www.dhclaims.com) in your preferred web browser and hit enter.

### STEP TWO

You should see the web page below. Click "Logon" to gain access to the website. For **first-time users**, click on "Click here to create a new user" to create an account. If you **already have an account**, proceed to enter your username and password, and click "Logon."

Home  
Logon  
Logoff

**DANIEL H. COOK**  
ASSOCIATES, INC. *i-Transact*

V 9.0.8

Please login by entering your assigned username and password

User Name

Password

[Click here to create a new USER...](#)

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### STEP THREE (FIRST-TIME USERS)

For **first-time users**, be sure to complete all fields on the "Create an Account" page. Keep in mind, each person covered needs to create their own account. Date of birth is what differentiates each member of the family. We recommend you choose an account username and password that is easy to remember. Click "create account."



- Home
- Ligon
- Logoff

**Create an Account**

1. Choose the TYPE of user you would like to create an account for:

2. Enter the following account information below:

Member Last Name:

Date of Birth (mm/dd/yyyy):

Last Four Digits of Insured SSN:

Account User Name:

Account Password:

Confirm Password:

### STEP FOUR (FIRST-TIME USERS)

After logging on for the first time, you need to set your preferences. You can leave these as is or modify and then click "continue."



Viewing : Alvarado, Angelica

- Ligon
- Member
- View Member Info
- My Plan
- Check Utilizations
- Find Provider
- Claim Status
- Request Id Card
- Talk To Us
- Manage Users
- Member Resources
- My Preferences**
- Logoff

1. Select your Coverage:

Member #	Subscriber Name	Relationship	Group Name	Plan Name	Eff. Date	Exp. Date
Selected Daniel H. Cook	, Angelica	Self	Daniel H. Cook	Daniel H. Cook	01/01/2007	12/31/9999

2. How many claims to display per page:

3. How many days back for claims lookup:

### STEP FIVE

Click on the links on the left-hand menu bar to gain access to different parts of the website. After selecting a link, please follow the directions located on the top of each page.



**View Member Info** – Allows members to view their personal and contact information. This link has been disabled.

**My Plan** – Displays an abridged version of the member's benefits.

- Ligon
- Member
- 1. View Member Info
- My Plan
- Check Utilizations
- Find Provider

OK  
INC

**Check Utilizations** –Allows the member to view \$ or units used as of given date.

**Find Providers** – Members can search for providers based on their Network and area.

**Claim Status** – Allows members to view the status of their claims

**Request Id Card** – Allows the member to print a temporary ID Card.

**Manage Users** – Allows the member to create, update or remove user accounts

**Member Resources** – Provides members with pertinent information concerning their benefit plan, Forms, and tips on choosing a provider and ways to expedite the handling and processing of their claims.

**Talk To Us** – This is a messaging center where members can leave questions concerning claims and benefits.

## CHECK UTILIZATIONS

Allows the member to view the amount (\$) and units used for the given “as of date.” Below is an example of the check utilizations page:

**DANIEL H. COOK ASSOCIATES INC. i-Transact**  
V 9.0.8

Viewing : \_\_\_\_\_, Anaelica - ( ta13868q ) - Daniel H. Cook, Daniel H. Cook, Effective period: 01/01/2007-12/31/9999

Member  
As Of Date:

\*Note - Next Available Date and Units will only be provided when the As of Date for Utilizations is set to today

Liability Type	Description	Units Used	Unit Value	Unit Type	Period	Next Available Date	Units Available
MM Lifetime \$ Max		\$0.00	\$40,000.00	Dollars	1 Lifetime	10/14/2008	\$40,000.00
Dental Yearly Maximum		\$0.00	\$1,200.00	Dollars	1 Years	10/14/2008	\$1,200.00
Major Medical Calendar Year \$ Max		\$0.00	\$5,000.00	Dollars	1 Years	10/14/2008	\$5,000.00
Vision Family Yearly \$ Limit		\$0.00	\$150.00	Dollars	1 Years	10/14/2008	\$150.00
Variable Supplemental		\$0.00	\$225.00	Dollars	1 Years	10/14/2008	\$225.00

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## VIEW CLAIM STATUS

On this page, the member can view all claims for the date range selected. Click on desired “claim number” and an EOB will be shown with more detailed information. This EOB can be printed or saved in different formats, like PDF or as a word document.



- Logon
- Member
- View Member Info
- My Plan
- Check Utilizations
- Find Provider
- Claim Status
- Request Id Card
- Talk To Us
- Manage Users

Search: (Please fill out the search criteria)

Claim Type:  Claim Status:  From:  To:

2 Claim(s) found

Claim Number	Provider Number	Provider Last Name	Provider First Name	Patient Account Number	Est. CLM #	Claim Status	Service Date From	Service Date To	Total Charges	Date Received	Form Type
0003636722	00203035	Provider 328)	In Net			Pending	09/17/2008	09/17/2008	\$500.00	09/18/2008	HCF C
0003636711	00203035	Provider 328)	In Net			Pending	08/15/2008	08/15/2008	\$200.00	09/18/2008	DEN C

- My Plan
- Check Utilizations
- Find Provider
- Claim Status
- Request Id Card
- Talk To Us
- Manage Users
- Member Resources
- My Preferences
- Logout

Daniel H. Cook  
EXPLANATION OF BENEFITS  
THIS IS NOT A BILL

MEMBER: ANGElica  
PATIENT: ANGElica  
PATIENT NUMBER: 00000001  
CLAIM NUMBER: 00000012  
PROVIDER: PROVIDER 328/IN NET  
EFFECT ACCT: PROVIDER 328/IN NET  
EFFECT DATE: 09/17/08  
EFFECT TIME: 11:14:23

Code	Procedure	Chrg	Denial	Reason	In Comp	Net Amt	Abmt	Ex-Gratia
1	01720 010 00000000 0754	10	10	10	000	00	00	00
Total								

\* Service Options  
Beneficiary: PROVIDER 328/IN NET

Remarks  
Check Date    Due Date    Due Amount    Excess    End Date

## HOW TO SUBMIT A CLAIM



## FILL OUT A CLAIM FORM

Your Dental and Vision Claim Forms can be found on the Daniel H. Cook Associates, Inc. website. Please navigate to [www.dhcook.com](http://www.dhcook.com) → Client Center → Member & Administrative Services, then use the “What is your group...” drop-down to find Mamaroneck Teachers’ Association.

Remember to fill out all relevant fields, some of which need to be completed by your provider, and to attach a copy of the provider’s bill showing itemized services, fees, and date.

## DENTAL CLAIM FORMS SHOULD BE SENT TO:



Mail Complete Form to:

Daniel H. Cook Associates, Inc.  
1040 Avenue of the Americas,  
24<sup>th</sup> Floor  
New York, NY 10018

Questions? You can call our Customer Service Department at (914) 250 – 0700.



**NOTE:** This benefit is available to active members and retired members who elect into the plan (at the time of retirement). Contact Elizabeth Harold (contact information below) for more information on how to utilize this benefit.

The plan covers the plan member, spouse, children to the age of 19, living at home, or dependent children in school and not gainfully employed to age 25. The plan is limited to the practice of law in the States of New York, Connecticut and New Jersey and within a 50-mile radius of your place of employment (see Reduced Fee # 9 & 10 below for member parent benefits).

### Included Services

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

### Matters Not Covered

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

### Reduced Fixed Fee Schedule for Non-Included Services

- Purchase or sale of house, condominium or cooperative apartment (non-primary residence):
  - House or condominium: \$1,500
  - Co-op: \$1,750

- Traffic Court matters: \$500 per pre-trial Court appearance or trial by agreement
- Administration or Probate of Estate: 15% discount on attorney's fees. Applies for member, spouse, parents, and parents-in-law
- Name change: \$1,000
- Uncontested Adoption: \$1,200
- Uncontested Divorce with Separation Agreement: \$1,200; Uncontested Separation or Divorce Agreement: \$1,200; excludes negotiation
- Personal Injury actions: 25% contingency fee
- Business and personal matters not set forth in the Fixed Fee Schedule: Fees shall be mutually agreed to by the attorney and client
- Simple will, living will, medical care proxy and general power of attorney to parents and parents-in-law of members: \$750 per couple or individual (NY and CT residents only for documents prepared and signed at our White Plains, NY office)
- Referral to Elder Law attorney with 20% discount on attorney's fees. Applies for member, spouse, parents, and parents-in-law



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

*Elizabeth Harold, Esq,*

*HAROLD, SALANT, STRASSIELD & ROTBARD, LLP*

*81 Main Street, Suite 205*

*White Plains, New York 10601*

*T: (914) 683-2500; F: (914) 683-1279*

*(Elizabeth Harold's Cell Phone, Emergency Use: (617) 851-4078)*

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*Paula Thomas, Paralegal; email: [pthomas@haroldsalant.com](mailto:pthomas@haroldsalant.com)*