PPFE Welfare Trust	COVERAGE	FORM	SEND CLAIM TO
DENTAL	**The BENEFIT YEAR is a CALENDAR YEAR**	**WHITE** **Account #** **540554** PP Educational Associates Trust	Claim form filled out by member and Dentist Send to: Guardian Group Dental Claims PO Box 981572 El Paso, TX, 79998-1572 1-800-627-4200
Individual- co-pay $5.50 per 18 paychecks=$99.00 Member plus spouse- co-pay $8.80 per 18 paychecks=$158.40 Family- co-pay $15.40 per 18 paychecks=$277.20 Network Provider Coverage To locate a participating provider please refer to: www.guardiananytime.com	100% preventative care (no deductible) 90% basic care ($50 deductible per person) 90% major care ($50 deductible per person) $2500.00 max./ year / member / dependent (family coverage) orthodontia, 90%, $1800.00 lifetime max./ member / dependent (family coverage) Non-college dependents are covered to age 20. Dependents attending college are covered until the **day of graduation up until 26th birthday**. Eligibility forms must be submitted each semester when registering as a full time student. For additional Savings you can use a Network Provider for up to 100% coverage with no deductible www.guardiananytime.com		

Life Insurance and AD and D **no copay required**	Death-$10,000 / AD&D $20,000	Enrollment Required	Claims made by PPEAT through Mutual of Omaha

Defensive Driving	Reimbursement for online course for member and family member, when submitted together.	**PINK**	Return to Trustee: **Nick Dean**

Trustees: Nick Dean, Kate Fenn, Jen Macri, Laura Rosato, Michelle Palmieri

PPFE Welfare Trust		FORM	SEND CLAIM TO
MEDICAL EXPENSE SUPPLEMENT	**The BENEFIT YEAR is a CALENDAR YEAR**	**BLUE**	Claim form filled out by member and *copies* of receipt(s)* Send to: Welfare Trust Fund PO Box 203 Pine Plains, NY 12567
Individual or Family **no co-pay**	**$200.00 / year** Covers "out-of-pocket" medical expenses. Doctor co-pays, prescription co-pays, and expenses for "out-of-program" care. Expenses may be incurred by member or dependents.		
VISION EXPENSE SUPPLEMENT	**The BENEFIT YEAR is a CALENDAR YEAR**	**YELLOW**	Claim form filled out by member and copies of receipt(s) * Send to: Welfare Trust Fund PO Box 203 Pine Plains, NY 12567
Individual- co-pay $3 per 18 paychecks = $54.00 **Family**- co-pay $7 per 18 paychecks = $126.00	**$200 / year: Individual $500 / year: Family** Covers additional vision expenses not covered by your health insurance.		

Claim forms are located in the common areas of each building. *Decreasing* coverage can only occur in September.
*** Medical and Vision reimbursement requests must be submitted *by* March 1st of the following year.**