Court Officers Benevolent Association
of Nassau County, Inc.
Active Health & Welfare Fund

2545 Hempstead Turnpike, Suite 105
East Meadow, NY 11554
(516) 794-0600

January, 2018

Board of Trustees

Dear Member:

We are proud to inform you of the benefits you are entitled to under our Health and Welfare Fund. The Trustees have worked long and hard to produce this comprehensive program.

The benefits of the Active Health and Welfare program are financed by contribution obtained through collective bargaining with the Office of Court Administration. The level of benefits is a product of prudent management and fiscal consciousness on the part of the Board of Trustees. As a Board, we strive to ensure that the benefits established and improved under the program are the best possible coverage attainable under the current collective bargaining contract contribution level.

Please read this booklet thoroughly to be informed about your current benefits. This booklet is yours for reference and also to offer to your health care professional for review in planning your health care under the program.

Fraternally yours,

Billy Imandt
Chairperson

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Eligibility Rules

Who Is Eligible

You are eligible for these benefits if:

a. you are a full-time or part-time employee of the Unified Court System in Nassau County, and

b. your employment is the subject of a Collective Bargaining Agreement by and between the State of New York and the Court Officers Benevolent Association of Nassau County.

c. eligible part-time employees will receive 50% of the full-time benefits.

d. part-time employees have the option to pay the difference between part-time and full-time H&W contributions out-of-pocket on an annual basis with an additional 3% administrative fee. This is a one-time option; if a part-time employee opts out they cannot opt back in. "Opt out" includes failure to pay.

If you were covered under this Plan on the date immediately preceding your retirement and receive a pension, you will continue to be eligible for benefits, as described in the Schedule of Benefits for retirees outlined in the retiree booklet, provided a retiree contribution is made on your behalf.

When You Become Eligible

You will become eligible on the first day of the month following six (6) consecutive months of continuous employment, or the effective date of your transfer to the Nassau County Bargaining Unit, whichever occurs later. If you were transferred directly from another Unified Court System Unit, you will be eligible immediately.

Eligible Dependents

Your eligible dependents under this Plan are:

1) Your lawful spouse **OR** your qualified domestic partner;

2) Legally separated spouse is not covered unless member participates in COBRA payments.

In order to register for coverage as a qualified domestic partner, the criteria, as outlined and enumerated in the Affidavit of Domestic Partnership, must be met prior to coverage. A qualified domestic partner is any unmarried individual who:

- has a close committed personal relationship with an unmarried participant, of the same or opposite gender; and
- has shared a household with an unmarried participant on a continuous basis for at least six (6) months prior to the request for coverage; and
- is at least 18 years of age; and
- is unrelated by blood to the unmarried participant; and
- is not a member of another domestic partnership.

The participant electing domestic partner coverage, and his or her domestic partner, must have jointly executed an Affidavit of Domestic Partnership and submit such documentation to the Fund Office.

3) Your unmarried children from birth to their 26th birthday provided they depend upon you for support and maintenance and are not employed on a full-time basis.

Stepchildren, legally adopted children (including a "proposed adopted child" during any waiting period prior to the finalization of the child's adoption), and children for whom you act as a legal guardian may be considered eligible dependents the same as your own children, only if they depend on you for support and maintenance, and you provide documentary proof to the Fund that is accepted by the Trustees. No child, other than one with whom you have one of the specified relationships designated above, may be considered an eligible dependent, regardless of whether the child lives with you or depends on you for support and maintenance.

However, a child who is physically or mentally incapable of self-support upon attaining age 26 and is an eligible dependent may be continued under the Health and Welfare Plan coverage upon submission that such dependent has been approved as disabled by the health insurance carrier or receiving Social Security disability while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. Additional proof may be required by the Trustees from time to time.

Eligible dependents for Term Life Insurance are your wife or husband or your qualified domestic partner and your unmarried children at least 6 months but less than 19 years old (23 if a full-time student). Legally separated spouse is not covered.

If you have a newly acquired dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your newly acquired dependent in the Plan, provided that you request enrollment **within 30 days after the marriage, birth, adoption or placement for adoption or claims will be denied until proof is received.**

No new dependent will be recognized for coverage under the Plan until they have been reported to the Fund Office by the Participant.

Appropriate documentation of eligibility as a covered dependent (i.e., birth certificate, marriage certificate, etc.) must be sent to the Fund Office along with the notification. Trustee's decision if the proof is sufficient is final. Coverage for such dependent will begin on the first day of the month following proper notification. Newly reported spouses (as defined by the Plan) and children are subject to all Plan rules and guidelines. A new dependent is defined as an individual who becomes a dependent of a Participant after the Participant is eligible to receive benefits.

No one will be eligible to be covered as a dependent while covered as a member of the Plan or while in military service, except as provided under USERRA (see Termination of Coverage and Military Leave).

Termination of Coverage and Insurance

The benefits for you and your eligible dependents will terminate on the day where any of the following occurs, unless otherwise noted:

1) If you cease to be an eligible employee for any reason, your eligibility ends **on the last day of the quarter** in which you worked;

2) If the Plan is discontinued or a specific benefit is terminated;

3) A dependent's coverage will terminate when he/she is no longer an eligible dependent, as defined by the Plan and/or when your coverage terminates;

4) If you take a leave from covered employment for service in a designated arm of the United States Armed Forces, contact the Fund Office for information. See USERRA provision hereafter.

Your Coverage Pursuant to the Family and Medical Leave Act of 1993 ("FMLA") As Amended

The applicable provisions of the FMLA shall apply.

Your Rights Pursuant to the Uniformed Services Employment and Re-Employment Rights of 1994 (USERRA) As Amended

If you take a leave from employment for service in a designated arm of the Armed Forces of the United States, you can continue coverage under the Plan in accordance with the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) for up to twenty-four (24) months of military service. You must elect to keep said coverage pursuant to USERRA and pay 102% of the cost of continuing your coverage. Moreover, if you elect USERRA coverage you may not then elect COBRA coverage when your USERRA coverage ends. Likewise, if you elect COBRA continuation coverage during this period of military leave, you may not then elect USERRA coverage when COBRA ends. The Plan will adhere to USERRA where applicable.

If you cease active work for any reason, contact the Welfare Fund Office immediately to determine what coverage, if any, can be continued in force.

Your Rights After Termination of Employment

If your employment terminates for any reason (except gross misconduct), you and your eligible dependents will be entitled to apply for COBRA continuation coverage. See COBRA section on page 28 for full details.

Questions Concerning the Plan

Contact the COBANC Fund Office or the Fund Administrator.

Schedule of Benefits
Active Members and Their Dependents

Claims must be submitted within 12 months of the date of service or care provided.

For Active Members Only

Life Insurance Benefit $20,000.00
Part-Time Member Life Insurance Benefit 10,000.00
Accidental Death and Dismemberment Benefit
Principal Sum 10,000.00
Part-Time Member Accidental Death and Dismemberment Benefit
Principal Sum 5,000.00

For Eligible Dependents of Active Members Only

Life Insurance Benefit
Spouse 3,000.00
Child (6 months to 26 years) 3,000.00

For Active Members and Their Dependents

Dental Expense Benefit
Maximum Amount (Annually Per Family) 5,000.00
Orthodontic Out-of-Network Expense Benefit (Lifetime Maximum Per Person) 2,655.00
Vision Care Expense Benefit
Maximum Amount ..... AS PER SCHEDULE
Hearing Aid Benefit (Every 4 years)
Maximum Amount 1,000.00
Hospital Income Benefit (up to 31 days)
Member 100.00/Day
Spouse 50.00/Day
Child 25.00/Day
Maternity Benefit
One Child 500.00
Each Additional Child 300.00
Maximum (Per Delivery) 1,100.00
Prescription/Medical Copayment Reimbursement Program
Maximum Benefit ..... 250.00 Per Member Annually
(Claim form must be submitted by April 15th for payment of prior year's claim.)

For Active Members Only

Supplemental Workers' Compensation Disability Benefit
Maximum Benefit 150.00/Week
Maximum Duration ..... 52 Weeks

Life Insurance Benefit

If you die from any cause while you are insured, the proceeds, as shown in the Schedule of Benefits, will be paid to your designated beneficiary. The proceeds will be paid as a lump sum.

Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form available at the Fund Office. The change will be effective when the Benefit Office receives the completed form.

Total and Permanent Disability

If you become totally and permanently disabled before age 50, your Life Insurance will continue, at no cost to you, for twelve (12) months from the last date premiums were paid on your behalf. Coverage will be extended during such disability, without payment of premium, if:

a) You send written proof of your disability to the Fund office or the contracted insurer no later than twelve (12) months after the start of your disability; and

b) The proof shows that you were totally and permanently disabled for at least nine (9) months, and that such disability is likely to continue to exist.

The contracted life insurance company will make final decisions regarding extensions.

You are considered totally and permanently disabled if, due solely to illness or injury, you are prevented from engaging in any business occupations or employment for renumeration or profit.

The Amount of Insurance That Is Continued

While you are totally and permanently disabled, the amount of Life Insurance continued, will be the amount in force at the time premium payments were discontinued, as a result of your disability. Any reduction in coverage based upon retirement will be applied to continuation of coverage, as of your normal, designated, retirement date.

Extension of Benefit

Premiums will be waived every twelve (12) months, if you submit proof of continuing total and permanent disability each year. Such proof must be received within three (3) months of the anniversary date the initial proof of disability was received by the Fund office or the contracted insurer.

Benefits under this extension will continue until the earliest of the following:

a) Thirty-one (31) days after the date you are no longer totally and permanently disabled;

b) Failure to furnish the contracted insurer with proof of your continued disability within three months of the anniversary date the initial proof of disability was received by the Fund office or the contracted insurer.

c) Failure to report for an examination by a Physician designated by the contracted insurer, if requested by the contracted insurer. This examination will not be required until your insurance has been continued under this extension for two (2) full years. Said examinations will be limited to once a year for each year after the two-year extension.

Dependent Life Insurance Benefit (For Dependents of Employees)

Insurance is provided for your eligible dependents in the amounts shown in the Schedule of Benefits. If one of your dependents dies, the Life Insurance proceeds will payable to you. However, if you die before your dependent, your dependent's Life Insurance proceeds will be payable on his/her death in accordance with applicable law.

Conversion Privilege (Employees and their Eligible Dependents)

A. If your insurance terminates because (1) You are no longer an eligible member; (2) Your employment terminates; or (3) If your insurance is reduced, on or after your attainment of age 60, in any increment or series of increments aggregating twenty percent or more of the amount of coverage in force before the first reduction on account of such age, you have the option of converting your Group Life Insurance into an individual life insurance policy.

You must make written application for such policy and pay the first premium within thirty-one (31) days after termination. A medical examination is not required. You may choose to invert to an amount equal to or less than the amount which terminated under this Plan. Such insurance will be one of the forms then being written by the contracted insurer, except term or disability insurance.

The premium for such policy will be based on:

1. Your age;

2. The class of risk to which you belong; and

3. The amount of insurance.

The covered conversion policy may, if you choose, be preceded by term insurance for of more than one year.

B. You may also convert to an individual life policy if your insurance terminated because (1) this Plan terminates; or (2) the insurance on the class to which you belong terminates.

You will have the right to convert under the same conditions and limitations as set forth Section A. However, the amount of such individual policy will not be more than the amount of the insurance on your life on the date of termination less any amount of life insurance under any group policy in which you may become eligible within forty-five (45) days of termination.

The individual life insurance policy will be effective at the end of the thirty-one (31) day conversion period, provided the application for conversion and conversion premium are paid within thirty-one (31) days of termination.

If you should die during the thirty-one (31-day) period allowed for conversion, the contracted insurer will pay your group life insurance benefit to the last Beneficiary you named, whether or not you have applied for conversion or paid the first conversion premium.

If you are no longer eligible for group life insurance because you no longer belong to an eligible insured class or if you terminate your employment, you may convert that benefit to any form of individual life insurance usually offered by the Company, except term insurance.

You will not need a medical examination. However, you must complete the application form and send it with the first premium payment to the Company no later than thirty-one (31) days after your group life insurance has terminated.

The face value of your new policy cannot be more than the amount you had under the group Plan. The rate you pay will depend upon your age (at the nearest birthday to the date of issue of the individual policy), your class of risk at the time of conversion, and face amount of your new policy.

No Life Insurance claim will be paid, unless written notice of your death, in a form approved by the insurer, e.g., death certificate, is received by the Fund office or the contracted insurer.

Facility of Payment

An insured person may be legally incapable of giving valid receipt of any payment due. In this case, the contracted insurer reserves the right, in the absence of the appointment of a legal guardian, to make payment to the party who, in its opinion, is entitled to such payment as required by New York Law. Payment so made shall discharge the contracted insurer's and Fund's obligation with respect to the amount so paid. If the insured person names more than one Beneficiary and does not know how much each Beneficiary should get, the total amount will be shared equally by all the Beneficiaries. If any Beneficiary has died before the insured, the other Beneficiaries will share the whole amount equally. If there is no living Beneficiary when the insured person dies, the contracted insurer will make payment to the insured's surviving parents; and if none to the surviving brothers and sisters. However, at the contracted insurer's option, payment may be made instead to the insured's estate.

Accidental Death and Dismemberment Benefit
Member Only
(24 Hour Coverage)

This benefit will be paid if, while insured, you sustain any of the losses mentioned below as a direct result of an accidental bodily injury. The loss must take place within ninety (90) days from the date of the accident for benefits to be payable.

This benefit is payable in addition to your other benefits under the group insurance plan. For loss of life, payment will be made to the beneficiary you name. For any other loss, payment will be made to you.

Your Benefits

Loss of Life ..... Principal Sum

Loss of Two Limbs, Sight of Both Eyes, or Loss of One Limb and Sight of One Eye ..... Principal Sum

Loss of One Limb or Sight of One Eye..... One Half the Principal Sum

The Principal Sum is the benefit amount shown in the Schedule of Benefits **(see page 9)**.

Loss of a Limb means the limb is severed at or above the wrist or ankle joint. Loss of Sight means total and irrecoverable loss of sight.

If you suffer more than one loss in any one accident, your benefits will be for the loss for which the largest amount is payable.

Exclusions

No benefit is payable for any loss caused directly or indirectly, wholly or partly, by:

a) Bodily or mental illness or disease of any kind;

b) Ptomaine's or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound) or disease or illness or any kind;

c) Intentional self-destruction or self-inflicted injury;

d) Participating in the commission of a felony; or

d) War or act of war, or service in the armed forces of any country.

Dental Expense Benefit
Member and Dependent Coverage

You are entitled to this benefit, if while covered, you or your eligible dependent incur “Covered Dental Charges" from a duly licensed dentist.

Your Benefits

A network has been assembled of participating dentists who have agreed to provide services for COBANC members with no out-of-pocket cost for covered dental services.

To receive the advantages of In-Network benefits, visit the Administrator’s website or contact the Fund Office to review the Directory of Dentists who participate in your dental plan. When making an appointment, be sure to identify yourself as an active member in the COBANC dental plan. You and your family members may go to any participating Capital Panel provider. Participating providers in the Capital PPO Network have agreed to provide services for COBANC members at reduced PPO fees. You need not go to the same dentist to receive In-Network benefits.

You are eligible to receive dental care from any licensed dentist not participating with the dental network. The Fund will pay for all covered services according to the Out-of-Network Schedule of Allowances. You will be responsible to your dentist for all charges not covered or not paid in full by the plan.

There are no deductibles, however there is a $5,000 per family annual maximum.

Meaning of Covered Dental Charges

“Covered Dental Charges" refers to the Maximum Amounts for services rendered, as listed in the Schedule of Dental Procedures, which, for the condition being treated, are necessary, customary and deemed by the profession to be appropriate.

If you or your dependents are transferred from one dentist to another in the course of treatment, or if more than one dentist provides services on a dental procedure, the benefits will be paid as though one dentist had furnished all treatment.

A charge will be incurred on the date the care or service is provided. However, the “insert" date of an appliance will be considered as the date that charge was incurred.

Predetermination of Benefits

If the proposed dental services include crowns, fixed or removable bridges, partial or full dentures or orthodontic services, a description of the procedures to be performed and an estimate of the dentist’s charges must be filed with the Fund’s Administrator before the course of treatment is begun. X-rays and other appropriate diagnostic and evaluative materials must be submitted with the claim form.

The predetermination process assures that both you and your dentist will know in advance what services are covered and what the Fund will pay.

If a predetermination is not filed, the Fund’s Administrator reserves the right to decide the benefits payable, taking into account alternate procedures, services or courses of treatment based upon accepted standards of dental practice.

Expenses That Are Not Covered

No benefits shall be payable for:

a) Any professional fees other than fees of the dentist or physician performing the treatment;

b) Dental fees due to an accidental bodily injury or illness that is employment related or payable under the Workers' Compensation Law, Occupational Disease Law or similar laws;

c) Which you are not required to pay;

d) Service performed solely for cosmetic reasons;

e) Replacement of lost or stolen appliance;

f) Replacement of a bridge, crown or denture within five (5) years after the date it was originally installed;

g) Replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;

h) Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;

i) Bite registrations, precisions or semi-precision attachments or splinting;

j) Orthodontia benefits for any dependents who have reach their 26th birthday.

k) Charges covered by a No-Fault Automobile Policy;

l) Any benefit that is claimed more than twelve (12) months after services were rendered.

Out-of-Network
Schedule of Dental Procedures
Dental Maximum is $5,000 Per Year Per Family

	Maximum Payment
Preventive & Diagnostic	
Periodic Oral Examination*	$19.00
Complete Series X-Rays**	54.50
Panoramic X-Ray*	45.00
Bitewing X-Rays* - 4 Films	18.50
Prophylaxis Adult*	34.00
Prophylaxis Children*	27.00
Topical Application of Fluoride*	23.50
Sealants (Permanent Teeth only)	26.50
Space Maintainers - Unilateral	125.50
Space Maintainers - Bilateral	181.50
Emergency Examination	17.50

* *Twice per calendar year*

** *Once per calendar year if performed by a different dentist or once during any 36 month period if performed by the same dentist*

Restorative	
Amalgam, one surface	$34.00
Amalgam, two surfaces	53.00
Amalgam, three surfaces	72.00
Composite, one surface, Anterior	36.50
Composite, two surfaces, Anterior	58.00
Composite, three surfaces, Anterior	78.50
Gold or Porcelain Inlays (as substitutes for fillings)	
One or two surfaces	130.00
Three or more surfaces	142.00

	Maximum Payment
Endodontics	
Pulp Capping, maximum per tooth	$20.50
Pulpotomy	42.50
Root Canal Therapy, Anterior	294.00
Root Canal Therapy, Bicuspid	390.50
Root Canal Therapy, Molar	487.50
Apicoectomy, Anterior	168.50
Oral Surgery	
Routine Extractions, each tooth	$53.00
Surgical Extractions, (sutures included)	94.50
Impacted teeth:	
Soft Tissue	117.00
Partial Bony	133.50
Full Bony	191.50
Retrograde Filling	39.50
Alveolectomy, w/Extraction, per quad	64.00
Periodontics	
For service provided by a dentist who is a Board Certified Specialist.	
Root scaling, prophylaxis, medication and minor bite correction:	
Each treatment	$73.00
Maximum in any 12 month period	730.00
Gingivectomy, each quad consisting of a minimum of five teeth	277.00
Gingivectomy, each quad consisting of less than 5 teeth (per tooth)	56.00

	Maximum Payment
Prosthetics Removable	
Complete Upper/Lower Denture	$562.50
Partial Upper/Lower Denture, Acrylic Base	475.00
Partial Upper/Lower Denture, Cast Base	585.00
Repairs/Relines to Dentures	
Replace Broken Tooth	55.00
Repair Framework	89.50
Add Tooth to Partial	55.00
Replace Clasp	69.00
Reline Full Upper/Lower – Lab (once every three years)	146.50/171.50
Rebase Full Upper/Lower (once every three years)	176.50
Prosthetics – Fixed	
Single Crowns	
Porcelain Crown	410.50
Porcelain with High Noble Metal Crown	495.50
Acrylic with High Noble Metal Crown	460.50
Stainless Steel Crown	102.50
Cast Post	107.50
Recement Crown	31.00
Bridgework	
Porcelain with High Noble Metal Abutment	495.50
Acrylic with High Noble Metal Abutment	460.50
Porcelain with High Noble Metal Pontic	456.00
Acrylic with High Noble Metal Pontic	421.00
Recement Bridge	43.00

	Maximum Payment
Implants/Crowns on Implants	
Endosteal Implant*	$1,200.00
**Twice per year with a lifetime maximum of $3,000.00*	
Implant Supported Prosthetics – Supporting Structure	
Custom Fabricated Abutment	107.50
Single Crowns – Abutment Supported	
Abutment Supported Porcelain/Ceramic Crown	410.50
Single Crowns – Implant Supported	
Implant Supported Porcelain Fused to High Noble Metal Crown	495.50

Orthodontia
(Study Models Required Prior to Start Date)

This benefit is available to eligible members of any age, as well as their dependent children and spouse/domestic partner. For more information on Dependent Eligibility, see pages 4-6.

Diagnosis and initial orthodontic appliance	$447.00
Active treatment per month of treatment	84.00
Maximum 24 months	2,016.00
Passive treatment per six (6) months of treatment	48.00
Maximum 24 months	192.00
Total Lifetime Maximum per Person	2,655.00

Out-of-Network
Vision Care Benefit
Member and Dependent Coverage

Benefits are provided for eye examinations performed by a duly licensed Optometrist or Ophthalmologist and for eyeglass lenses, contact lenses and eyeglass frames ordered by them.

The Fund will pay the charges for covered eye examinations and supplies, up to the maximum listed in the Schedule of Vision Care.

Contact the Fund Office regarding In-Network benefits.

Schedule of Vision Care

Annual Maximum Benefit

EYE EXAMINATION - INCLUDING REFRACTION

By Optometrist without ophthalmological tests $18.00
With ophthalmological tests 28.00
By Ophthalmologist 50.00

LENSES

Each Single Vision Lens 21.00
Each Bifocal Lens 29.00
Each Trifocal Lens 36.00
Each Progressive Lens 42.00
Each Transitional Lens 50.00
Each Lenticular Lens 87.00
Each Contact Lens 72.00

FRAMES

To be included in contact lens allowances 60.00

For Members Only

Laser Surgery (in lieu of above indicated schedule) will be reimbursed at $300.00. Member must sign waiver of rights for scheduled vision care benefits for a period of two years after dates of surgery. Examinations will be covered.

Exclusions

Vision Care Expenses benefits are not payable for:

1. More than one eye examination in a calendar year.
2. More than one pair of glasses (two lenses one pair of frames), in a calendar year, including benefit paid for contact lenses.

   (Note: This benefit is either one pair of glasses per calendar year or one pair of contact lenses per calendar year)
3. Sunglasses, unless used to correct vision.
5. Replacement of lost, stolen or broken lenses or frames furnished under this benefit.
6. Eye examinations required (1) as a condition of employment, which the employer is required to provide by a labor agreement, or (2) by a governmental body.
7. Special procedures such as orthoptics and visual training or medical or surgical treatment of the eye.
8. Services or supplies received as a result of an accident related to employment or disease covered under a Workers' Compensation Law or similar laws. Services or supplies (a) furnished by or for the U.S. Government; or (b) furnished by or for any other government unless payment is legally required; or (c) to the extent provided under any governmental program or law under which the individual is, or could be covered. Anything not necessary for vision care; charges in excess of those usually made when there is no coverage or in excess of the general level in the area.

Hospital Income Benefit
Members and Dependents Only

The Plan will pay as indicated in the Schedule of Benefits for up to thirty-one (31) days for a hospital confinement ordered by a doctor as a result of an accident or sickness, excluding pregnancy.

The day on which you are discharged from the hospital will not be considered as a day of confinement.

Separate hospital confinements due to the same cause will be considered one confinement, if separated by less than two (2) weeks of full-time work with respect to you, or with respect to your dependent's if separated by less than two (2) weeks of your spouse's or child's return to normal activities.

Exclusions

Confinements due to an act of war (either declared or undeclared), or while on full-time active military duty are not covered.

Routine nursery care of a newborn is not covered under the benefit.

Maternity Benefit
Member and Spouse Only

The maternity allowance is a benefit payable in all cases where a child is delivered. The Fund will allow $500 for a child born to you or your spouse. In cases of multiple births, the Fund will allow $300 each for the second and third child.

In order to receive this benefit, the member must submit a photocopy of the child's birth certificate to the Fund Office. After your documentation has been approved and your dependent enrolled, you must submit a claim form to the Fund Administrator. The Administrator will process the claim and forward a check to the member shortly thereafter. This benefit is not assignable to any third party, including the hospital. Adoptions will be considered as an eligible claim provided that the adopted child is less than one (1) year of age when the adoption is finalized.

Hearing Aid Benefit
Member and Dependent Coverage

This Plan will pay up to $1,000 for the purchase of a pair of hearing aids (an individual hearing aid will be reimbursed up to $500) once every four (4) years. You or your eligible dependent must submit a claim form and attach a letter of medical necessity and receipts indicating the cost of the hearing aid. This benefit will be coordinated with any other medical insurance/coverage, which covers you or your eligible dependents. In no event will the member be reimbursed for more than the cost of the device. This benefit is not assignable to any third party.

Prescription/Medical Copayment Reimbursement Program
Member and Dependent Coverage

This benefit allows for reimbursement of any copayments or unreimbursed medical/dental expenses for prescription medications or office visits for you and your family. Submit proof of payment along with a completed claim form. The maximum allowable benefit is $250 per year per family. The claim form **must** be submitted by April 15th for payments of the prior calendar year's claims.

Supplemental Workers' Compensation Disability
Members Only

If you become sick or disabled because of a job related accident or illness, the Plan will pay $150 a week for the member only. The benefit will be effective after the member has been off the payroll for thirty (30) days and a Workers' Compensation claim has been filed. The plan will pay the $150 weekly benefit for a maximum of fifty-two (52) weeks, provided the Workers' Compensation benefit has been paid.

Heart Scan Benefit
Member and Spouse Only

The Fund will pay $100 towards the Heart Scan benefit. The member or member's spouse/domestic partner will have a copayment of $99. There is no age restriction for this benefit. For more information and to schedule an appointment, please call **866-518-1112**.

Inner Imaging
Electron Beam Tomography (EBT)
Member and Eligible Dependent
Ages 45 and Over

Members may receive an Electron Beam Tomography (EBT) test at offices of contracted providers. This benefit is available to both Active members and their qualified dependents ages 45 and over.

Advanced scans detect coronary artery disease, long before symptoms occur. These scans test for Heart Disease, Lung Disease, Diseases in the Abdomen and Pelvic Area.

On the day of your scheduled appointment, members will be required to pay a $200 copayment.

As with all the benefits of this plan, part-time employees will receive 50% of the full-time benefit.

For more information and to schedule an appointment, please call **212-777-8900**.

Coordination of Other Plans

In the event a covered person under the benefits of the Health and Welfare Fund is also covered under another group benefit plan which provides dental and hearing aid benefits, and such plan is provided through the auspices of any employer or educational institution, there will be a "Coordination of Benefits" regarding reimbursement by this Health and Welfare Fund Plan.

This coordination will apply in the event an expense is incurred for a covered event under this Health and Welfare Fund Plan, which also is covered under the other plan. A determination will be made as to which plan is the "first" plan (or primary) and which is the "second" plan (or secondary). The method determining which plan is "first" is based on the following rules:

1. A plan covering a person as an employee will pay benefits first. A plan covering a person as a dependent will pay second.

2. If a dependent child is covered by both parents' plans, the benefits of the Plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be primary. The benefits of the plan that covers the child of the parent whose date of birth excluding year of birth, occurs later in a calendar year, will be determined secondary. This is known as the "Birthday Rule" if a plan containing the "Birthday Rule" is coordinating with a plan that contains the "Gender-based Rule" and as a result, the plans do not agree on the order of benefits, the "Gender-based Rule" will determine the order.

3. When the parents are divorced or separated the order is determined:

   a) by a court decree or separation agreement, which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first. The order or agreement will supersede any previous provision stated above.

4. If a person is covered under more than one plan, the plan he or she was covered under longer pays first.

   If this Plan is the first plan, it will pay its benefits as if there were no other such plan.

   If the Health and Welfare Plan is the second plan, it will pay its benefits as if there were no other such plan. However, the Health and Welfare Plan will pay up to 100% of the Plan's allowable amount offset by what is paid by other plans.

These provisions will not apply to situations where both a husband and a wife are covered under the Plan. In these cases, each will be considered to be the primary covered individual. However, the Plan will never pay more than the total bill submitted for payment.

Continuation of Coverage (Self-Pay) As Required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

For you or your covered dependents who are not covered under any other group health care plan when your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may continue coverage under This Plan for a period of up to eighteen (18) months. However, if you are determined under the terms of the Social Security Act to have been disabled at the time of your termination of employment or reduction in hours, you may continue your dental coverage under This Plan for an additional eleven (11) months after the expiration of the eighteen (18) month period. During the additional eleven (11) months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding eighteen (18) months. In addition, should you die, become divorced or legally separated, or become eligible for Medicare, your covered dependents who are not covered under any other group health care plan may continue coverage under This Plan for up to thirty-six (36) months. Also, your covered children who are not covered under any other group health care plan may continue coverage under This Plan for up to thirty-six (36) months after they no longer qualify as covered dependents under the terms of This Plan.

This continuation will terminate on the earliest of:

a. the end of the 18, 29 or 36 month continuation period, as the case may be, in accordance with applicable law and rules;

b. the date of expiration of the last period for which the required payment was made;

c. the date This Plan is canceled.

Notice will be given when you or your covered dependents become entitled to continue coverage under the Plan. You, or they, will then have at least sixty (60) days to elect to continue coverage. However, you or your covered spouse or your covered child must notify the Employer within sixty (60) days in the event you receive a determination of disability under the terms of the Social Security Act, you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under This Plan.

Any person who elects to continue coverage under the Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance. If you fail to pay the full payment by each due date (or within the thirty (30) days grace period), you will lose all COBRA coverage. Once your COBRA coverage terminates for any reason, it cannot be reinstated.

If you have any questions about COBRA continuation coverage, please contact the Fund Office or the Administrator.

Claim Processing

Life Insurance and Accidental Death & Dismemberment

The benefits will be processed and paid in accordance with the terms of the policy.

All Other Benefits

When a claim is to be made, you or your provider may submit a universal claim form for services rendered or you may obtain a claim form from the Fund Office or the Fund's Administrator.

Make certain that all required information is completed on the claim form. The completed claim forms and necessary documentation should be sent to the Fund Administrator for benefit processing. Dental and vision claim payments will be made directly to you, the member, unless you have assigned the payment to the provider of services. Hospital income, maternity and hearing aid benefits are not assignable.

Claim Appeals

If your claim for benefits is denied, in whole or in part, for any reason, the Plan will send you written notice of its decision within ninety (90) days after receipt of claim. This may increase to 180 days depending on circumstances. The notice will include the specific reason or reasons for the denial; the special reference to pertinent Plan provisions on which the denial is based; a description of any additional material or information necessary for you to complete your claim, and an explanation of why such material or information is necessary (if applicable); and appropriate information as to the steps to be taken if you wish to appeal the denial of your claim.

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal, you must write to the Trustees within ninety (90) days after you receive the Plan's denial notice. Your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY MY BENEFITS. YOUR DENIAL NOTICE TO ME WAS DATED _____, 20_____". If this statement is not included, then the Trustees may not understand that you are making an appeal as opposed to a general claim inquiry.

If you have chosen someone to represent you, with respect to your appeal, and if your representative(s) writes the appeal to the Trustees, your authorization must be given and you must sign and notarize the authorization statement. Otherwise, the Trustees will not be sure that you have actually authorized someone to represent you. The Trustees will not communicate about your situation to someone unless the Trustees are sure the individual is your chosen representative. If you appeal, you or your duly authorized representative(s) may review pertinent documents concerning your denial and may submit to the Trustees any issues/comments you have in writing.

If you do not receive any decision at all from the Plan (regarding an appeal for benefits) within ninety (90) days from the date you submitted such appeal (this period may increase to 180 days depending on circumstances), you may appeal to the Trustees in the same manner as previously stated.

The Trustees' decision, with respect to your appeal, will be made promptly, and will not ordinarily be made more than ninety (90) days after the Plan receives your written appeal. If circumstances require an extension of time for processing, a decision shall be rendered as soon as possible, but no later than 120 days after your appeal is received. If such an extension of time for review is required because of circumstances, written notice of the extension will be furnished to you (or your representative) prior to the beginning of the extension. The Trustees' decision on review will be in writing and will include specific reasons for their decision, written in a manner calculated to be understood by you, as well as specific references to the Pertinent Plan provisions on which their decision is based.

If the request for review involves a claim for benefits that are provided by the contracted insurer, the review and final decision shall be made by the contracted insurer.

Since the Trustees and/or their designee (the contracted insurer) have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan, the final decision of the Trustees or the contracted provider, with respect to their review of your appeal shall be final and binding upon you. However, if you disagree with the final decision of the Trustees with respect to your appeal, you may commence a legal action against the Plan.

The above time periods are not applicable to the contracted insurer.

Legal Proceedings

The time in which to begin an action at law or in equity shall be brought to recover under the Policy or Plan shall be in accordance with New York State Law.

The laws of the State of New York shall be applied in all cases.

Overpayment of Claims

If, at any time, you received an overpayment of any claim, you are required to return the overpayment when requested by the Board of Trustees.