Civil Service Bar Association
Security Benefits Fund

Affiliated With Local 237
International Brotherhood Of Teamsters

216 West 14th Street
New York, NY 10011

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23-7439425

Plan Year
January 1 - December 31

Type of Plan
Supplemental Benefit Plan

Type of Plan Administration
Insured and Self-Insured

Administrative Manager

Amalgamated Employee Benefits Administrators
333 Westchester Avenue
White Plains, NY 10604
(866) 647-4617
csbainfo@amalgamatedbenefits.com

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Your Plan At A Glance

Dental Program (For Full Time And Part Time Members And Their Covered Dependents)

$50 per person, $100 per family calendar year deductible, then covered per fee schedule which is accepted as payment in full by participating dentists to $2,500 maximum payment per person per calendar year. Orthodontics: maximum of 24 active months of coverage except for medically necessary pediatric orthodontics.

Prescription Drug Plan (For Full Time Members And Their Covered Dependents)

(Effective June 1, 2014, this program is administered by Teamsters Local 237 Welfare Fund. Please call them at (212) 924-7220 with any inquiries regarding the prescription drug plan.)

Card program with a 5% co-payment for generic drugs, a 15% copayment for preferred brand name drugs, and 50% co-payment for non-preferred brand name drugs, Mail order available for a 90-day supply of maintenance drugs with a 5% co-payment for generic drugs, a 15% co-payment for preferred brand name drugs, and a 50% co-payment for non-preferred brand name drugs. In addition, member will be responsible to pay the difference between the cost of the brand name and the generic equivalent plus the generic co-pay when brand name medications have a direct generic equivalent available.

The Plan has a $100 calendar year deductible per adult (dependent children waived).

The Plan covers for all generic/Brand Oral Contraceptives, contraceptive patches, Nuvaring and oral emergency contraceptives at the generic copay.

The Plan requires Prior Authorization for the **Proton Pump Inhibitors (PPIs)** therapeutic drug class.

Quantity limitation on **Sleep Aids**. In compliance with the guidelines issued by the FDA, coverage of Sleep Aids are limited to 10 pills/month.

Mandatory Step Therapy or Prior Authorization on all new or refill prescriptions for brand name **Statin** class drug.

Two Incentives to using First Line Generic Drugs
A) First Line generic drugs listed above will be available to you **Free of Charge**.
B) The Annual $100 Deductible is waived on all First Line generic drugs filled.

Please note that for certain prescription drug claims, prior authorization or precertification may be required by Aetna before a prescription is filled. To find out if a prescription drug requires such prior authorization or precertification by Aetna, please contact Aetna Rx Member Services at (855) 352-1599.

Life-Style Benefit (For Full Time Members And Their Covered Dependents)

Effective 2/1/2017 all Life-Style benefits will be covered through the Aetna PBM. The first $200 per family will be covered at 100%. 5% copay will apply after the first $200 of the benefit. No deductible.

[1] Step therapy/prior authorization will not apply to prescriptions presented for Lipitor 80 mg.

Your Plan At A Glance (Contd.)

Please note that because Aetna processes all Life-Style Benefit prescription drugs as of 2/1/2017, a 5% copay will be applied to all prescriptions at the time of purchase. To receive full coverage for the first $200 of Life-Style Benefit drugs each calendar year, please submit itemized receipts showing your copay costs for Life-Style Benefit drugs, for up to a $10.00 reimbursement per year from Amalgamated Employee Benefits Administrators. You may submit your receipts to Amalgamated Employee Benefits Administrators throughout the year as soon as you or your covered dependents incur $10.00 in copay costs per calendar year for a Life-Style Benefit drug.

Newborn Benefit (For Full Time Members)

$500 benefit for birth of a child or adoption of a child who is up to 18 years of age.

24 Hour Nurse HelpLine (For Full Time and Part Time Members And Their Covered Dependents)

Contact registered nurses to assist with health questions and/or listen to over 1000 pre-recorded tapes dealing with medical topics.

Hearing Aid Benefit (For Full Time Members And Their Covered Dependents)

Up to $3,000 per device per person once every three years and up to $250 per mold once every three years.

Optical Benefit (For Full Time Members And Their Covered Dependents And For Part Time Employees)

Voucher Program - Eye exam and one pair of eyeglasses or contact lenses or a supply of disposable lenses per person once per calendar year through participating providers, or **Reimbursement** - Effective 1/1/2020, up to $150 per person per calendar year reimbursement if using a non-participanting provider.

Short Term Disability Coverage (For Full Time Members)

50% of gross weekly earnings up to $300/week, for a maximum benefit of 13 weeks.

Long Term Disability Coverage (For Full Time Members)

50% of gross salary to $3,000/month to age 65.

Life Insurance Coverage (For Full Time And Part Time Members)

$25,000 up to age 65; $5,000 ages 65-69; $1,000 ages 70 and over.

One half of the benefit is paid from the first through the twelfth month of employment as a member, with full coverage thereafter.

Basic Information

What Is The Security Benefits Fund?

The Security Benefits Fund provides benefits, in addition to the Basic Medical Plan provided by the City of New York, for members covered by collective bargaining agreements which provide for the appropriate contributions for this coverage.

The purpose of the Plan is to provide and/or enhance benefits which are not covered under the Basic Plan.

How To Use This Booklet

This booklet is called a Summary Plan Description. It is designed to help you understand how your Plan works. It is important for you to read this booklet to understand what you are entitled to, and to make the best use of your Plan coverage.

Should you have any other questions about the Plan and how its coverage works, contact Amalgamated Employee Benefits Administrators, 333 Westchester Avenue, White Plains, NY 10604, 866-647-4617 for assistance.

Who Pays The Cost Of The Plan?

The cost of the Plan is paid by the City of New York through regular payments to the Fund.

Who Is Covered?

You:

If you work for the City of New York Mayoral Agencies, Housing Authority, New York City Transit Authority, New York City Employees Retirement System, or other New York City employers who are covered by a Welfare Fund Agreement with the CSBA Security Benefits Fund.

Full Time Member:
Full time member is defined as someone who works 35 or more hours a week and for whom the City of New York remits a full time contribution to the Fund. Attorneys who are hired as part time attorneys by their Department and work 35 hours or more are not considered full time members.

Part Time Member:
Part time member is defined as someone who works at least 70 hours in a 28 day period and for whom the City of New York remits a part time contribution to the Fund. Attorneys who are hired as part time attorneys and work 35 hours or more a week are considered part time.

Your Dependents:

Your eligible dependents are:

- Your spouse or your domestic partner if registered with the City of New York. Your spouse must not be legally separated or divorced from you.
- Your dependent children until they become age 26. The term "dependent children" includes any child who is related to you by blood, marriage or adoption and any other child if that child lives in your household in a parent-child relationship and is dependent upon you, your spouse or your registered domestic partner for support.
- Your adopted children are covered from the time the child is placed with you for adoption.
- Your unmarried dependent children age 19 and older who are incapable of self-sustaining employment due to mental illness, developmental disability, physical handicap or mental retardation, if the condition began prior to age 19 and the child has been continuously covered for Fund benefits prior to age 19.[1]

If your dependents are covered by the Fund as employees, they are not considered covered dependents.

Qualified Medical Child Support Orders:

The Plan will provide health care coverage in accordance with a Qualified Medical Child Support Order, which is any judgment, decree or order issued by a court or through an administrative process established under State law which recognizes a child or children's right to receive benefits under a group health plan in which the child's parent is an eligible participant.

The Qualified Medical Child Support Order must specify: the name and last known mailing address of the participant and the name and address of each of the eligible children, a description of the type of coverage to be provided, the period to which the order applies, and each plan to which the order applies.

The Qualified Medical Child Support Order can not require the Plan to provide any benefit or option not otherwise provided under the Plan.

[1] The Fund Office must be notified of any dependent children with any such condition when they become age 19 and a medical form must be completed by a physician certifying that the condition results in total disability and in complete financial dependence on the participant. Periodic updating of the medical condition will be required and the Fund may require that the dependent be examined by Fund physicians.

When Coverage Begins

All coverage begins on your date of employment. However, benefits will not be paid until contributions are received from the City of New York on your behalf. When contributions are received, benefits will be paid retroactively to your date of employment. Coverage for your eligible dependents begins at the same time as your coverage.

If you are a part time member, your dependents are eligible only for dental coverage.

If you wish to add a dependent after your initial enrollment, the following documentation must be sent to Amalgamated Employee Benefits Administrators, 333 Westchester Avenue, White Plains, NY 10604:

- to add a dependent acquired through marriage or registration of domestic partnership, a copy of your Marriage Certificate or Registration of Domestic Partnership must be provided;
- to add a new baby or adopted child, a copy of the Birth Certificate or Adoption Papers must be provided;
- to add a stepchild, the following information must be provided:
    - a signed, notarized affidavit indicating that your stepchild resides with you on a full time basis,
    - a copy of your most recent tax return listing the stepchild as an eligible dependent or a letter from your accountant or attorney stating that the child will be eligible on your next tax return,
    - a copy of your medical carrier's I.D. card listing your stepchild as an eligible dependent or a copy of the application enrolling the child,
    - a copy of court documentation identifying you as the child's legal guardian (if applicable).

All members are required to complete a Member Benefit Questionnaire and report all changes in any information therein to Amalgamated Employee Benefits Administrators at once. Do not assume that because you notify your medical provider that your Fund will be notified of any change in status. It is your responsibility to report any changes to Amalgamated Employee Benefits Administrators immediately.

When Coverage Ends

Coverage ends when the City of New York no longer contributes to the Fund on your behalf. Furthermore, if you are not on the City payroll for at least one day during the second monthly pay cycle, the City is not obligated to contribute on your behalf for that month.

Coverage may also be terminated in the following situations:

- If a member is on an unpaid medical leave, the City of New York is not obligated under the Family Medical Leave Act to continue contributions on behalf of that member;
- If you become legally separated or divorced or dissolve a Registered Domestic Partnership, benefits terminate for the spouse or registered domestic partner.

You may have the right to a temporary extension of your benefits after your coverage ends. Please see "Your COBRA Rights" for an explanation of this benefit.

Certificates Of Coverage

When you leave covered employment, the Fund will provide you with a Certificate of Coverage, which you may present to a new employer who provides health care coverage.

How the Plan Works With Other Coverage

Coordination of Benefits

Your Plan has a **Coordination of Benefits (COB)** provision that determines how payments are made if you or your dependents are covered by more than one health care coverage plan. Like most health care coverage, your Plan follows the "primary" and "secondary" rules of coverage. This means that in each case, the coverage that is considered primary pays first to the full extent of its coverage. Then, the secondary coverage pays an additional amount, up to the full extent of its coverage. Coverage is up to but never more than 100% of the actual covered charges.

If you purchase an individual health care policy, including Medicare supplementary coverage, that coverage is always primary and the Fund's coverage is secondary.

If the coverage does not have a coordination provision, that coverage is considered primary and always pays first. If both coverages have coordination provisions:

- the coverage that covers the patient as a dependent is secondary and therefore pays second, except as stated above.
- when a dependent child is covered by the coverage of more than one parent and all coverages have a coordination provision, the coverage of the parent whose birthday occurs first in the calendar year pays first, and the coverage of the parent whose birthday occurs later in the year pays second. If both parents have the same birthday, the plan that has covered the parent longer pays first.

However, where the parents are divorced or separated and both coverages have coordination provisions, payment will be made as follows:

- the coverage of the parent with custody pays first
- the coverage of the step-parent with custody pays second
- the coverage of the non-custodial parent pays last.

If there is a court decree that states otherwise, that court decree will govern.

If an individual is covered as a result of having purchased continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA), and is also covered under a new or current employer's group plan (to the extent possible under the terms of the Plan and COBRA) the following shall be the order of benefit determination:

- the plan covering the person as an employee (or as that employee's dependent) pays first,
- the coverage purchased under the plan covering the person as a former employee (or as that employee's dependent) provided according to the provisions of COBRA pays second.

Medicare Coverage

Medicare is the federal government's health insurance program for individuals age 65 and older. Individuals under age 65 who are disabled may also be entitled to Medicare.

Generally, if you are working in covered employment and you are entitled to Medicare, the Plan will provide its full health care coverage first and Medicare will pay second.

Automobile No-Fault Or Financial Responsibility Law

If your injury is caused by an accident in a state that is covered by an automobile no-fault insurance law, or similar law relating to motor vehicle coverage and financial responsibility when not entitled a "No-Fault" law, the automobile no-fault insurance is responsible for paying the covered charges for that injury first. The Plan will then cover the balance of the covered charges that were not covered by the automobile no-fault insurance up to the limits of the Plan's coverage.

Liability Coverage (Subrogation)

Conditional Benefit Payments

If you, your spouse or your eligible dependent has medical expenses as a result of an illness or injury for which a third party is, or may be, held responsible, the Fund may make advance expense reimbursements to, or payments on behalf of, you, your spouse or your eligible dependent, subject to the Fund's subrogation rights. However, before any such reimbursements or payments will be conditionally made, you, your spouse or your eligible dependent (or your eligible dependent's legal guardian if your eligible dependent is a minor) shall execute an agreement that acknowledges and affirms (1) the conditional nature of the reimbursements or payments and (2) the Fund's rights of subrogation, as provided for below.

Subrogation

If you, your spouse or your eligible dependent receives any benefits arising out of an injury or illness for which you, your spouse or your eligible dependent (or your, your spouse or your eligible dependent's guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the Fund for such benefits shall be made on the condition and with the understanding that the Fund will be reimbursed.

Such reimbursement will be made by you, your spouse or your eligible dependent (or your, your spouse or your eligible dependent's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of you, your spouse or your eligible dependent (or your, your spouse or your eligible dependent's guardian or estate) from: (1) any policy or contract from any insurance company or carrier (including your, your spouse's or your eligible dependent's insurer and/or (2) any third party, plan or fund as a result of a judgment or settlement. You, your spouse or your eligible dependent on behalf of himself (or his guardian or estate) acknowledges and agrees that the Fund will be reimbursed in full before any amounts (including attorney fees incurred by you, your spouse or your eligible dependent or his guardian or estate) are deducted from the policy, proceeds, judgment or settlement.

The Fund will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your, your spouse's or your eligible dependent's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under The Fund arising out of the injury or illness for which you, your spouse or your eligible dependent (or your, your spouse's or eligible dependent's guardian or estate) has, may have or asserts a cause of action. In addition, the Fund will be subrogated for attorney's fees incurred in enforcing its subrogation rights hereunder.

Workers' Compensation Coverage

The Plan does not cover any charges for which there is entitlement to Workers' Compensation or for injuries or illnesses that arise out of your employment. Workers' Compensation is a state administered program which offers coverage for health care costs and loss of earnings resulting from an occupationally related disease or accident.

Additional information about Workers' Compensation can be obtained from the New York State Workers' Compensation Board.

Government Coverage

If coverage is available for any condition or treatment covered by a government program (such as through a state hospital), or pursuant to any federal, state or municipal law, coverage under the Plan will not be provided. Except as provided elsewhere herein, Medicare shall not be deemed to be such a government program.

How to File A Claim

All claims, except for those submitted electronically, must be submitted in writing to the addresses below and must include the member name, or, the patient name and such other information as required. They must also be signed by the patient or authorized representative. If you are the one filing a claim, you must obtain an appropriate claim form.

In order to appoint an authorized representative, the patient must complete and return an Authorization for Release of Information-Appointment of Authorized Representative form which can be obtained from the Fund office or Amalgamated Employee Benefits Administrators.

A claim must be filed within 12 months from the date of service. Proof of claim must include an itemized bill including date, type and charge for each service rendered.

The Fund office or its administrator makes all claim decisions. Payment will be made to the facility or health care provider unless receipts are submitted showing that the bill has already been paid, in which case, payment will be made directly to the patient or legal guardian. Adverse claims decisions may be appealed (see "Your Right to Appeal").

What Is A Claim?

A claim is a request for benefits submitted in accordance with Fund rules.

Determination of Benefits

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the Plan that the Plan Administrator in its sole discretion determines you are entitled to receive.

Manner and Content of Notification of Initial Benefit Determination

If your claim for benefits has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reason(s) for such denial with references to the specific plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim (including an explanation as to why such information is necessary);
- a description of the review procedures and the time limits applicable to such procedures; and

- that if the benefit determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Your Right To Appeal

If your entire claim, or part of your claim is denied, you have the right to appeal. The following appeals procedures apply only to claims for benefits provided under this Plan to Participants.

Appeal of Adverse Benefit Determination

If you disagree with the determination, you may request an appeal of such denial by written request filed no later than one hundred and eighty (180) days after the receipt of the denial notice.

Below is listed the name and address of the reviewing body you must mail written notification to:

Dental benefits:

Self Insured Dental Services
Dept. 33 - Appeals
P. O. Box 9005,
Lynbrook, NY 11563

Please note that you may make a second and final appeal of a determination on review by Self-Insured Dental Services' ("SIDS") by submitting a written second level appeal to the Trustees of the Fund, c/o Amalgamated Employee Benefits Administrators, 333 Westchester Avenue, White Plains, NY 10604, Attn: Appeals, within 60 days of receiving your determination on review from SIDS.

Disability benefits:

UNUM Provident
c/o CSBA/Amalgamated Employee Benefits Administrators
333 Westchester Avenue
White Plains, NY 10604
Attn: Appeals

Life Insurance benefit:

Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains, NY 10604
Attn: Group Policy Dept. - Appeals

For appeals regarding all other benefits:

Written notification must be mailed to the Trustees of the Fund, c/o Amalgamated Employee Benefits Administrators, 333 Westchester Avenue, White Plains, NY 10604, Attn: Appeals.

Review Process

In connection with your right to appeal the initial determination regarding your claim, you:

- will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
- will be provided, at your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination; and
- will, in the case of disability, have your claim reviewed by a health care professional, if the denial was based on a medical judgment; this individual may not have participated in the initial denial.

Manner and Content of Benefit Determination on Review

If your appeal under this Fund has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reasons for the decision;
- references to the specific plan provisions on which it was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

If discrepancies occur between the Summary Plan Description and the basic plan documents, the language of the basic plan documents are controlling. Basic plan documents are defined as a) Citywide Bargaining Agreement, b) Unit Bargaining Agreement, c) Welfare Fund Agreement signed between the C.S.B.A. Welfare Fund and the Office of Collective Bargaining and/or Government Authorities, d) Citywide P.I.C.A. agreement, and e) existing disability and life insurance policies.

The decision of the receiving body shall be final and binding on all parties.

Your COBRA Rights

On April 7, 1986, a Federal Law, The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272, Title X, commonly known as COBRA), was enacted requiring that most employers sponsoring group health plans offer employees and their families the opportunity for temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you of your rights and obligations under the continuation coverage provisions of the law. You and your dependents should take the time to read this section carefully.

Important Note: You will be required to pay for this continuation coverage. The Plan will not pay your premium. The cost of full individual continuation coverage will be 102% of the cost of group coverage. If you are eligible according to the rules set forth below to purchase the additional 11 months of coverage available to disabled members and dependents, the cost will be 150% of the group coverage for those 11 months. However, you will not be required to pass a medical examination or any other test of insurability.

If you elect not to enroll in the full coverage you must select at least one core benefit as defined by the Fund.

If you are employed by an employer who contributes to the Civil Service Bar Association Security Benefits Fund, you have a right to choose this continuation coverage if you lose your Supplemental health coverage because of any of the following qualifying events:

1) A reduction in your hours of employment;

2) The termination of your employment (for reasons other than gross misconduct on your part); or

3) Your employer's commencement of a bankruptcy proceeding under the U.S. Bankruptcy Code.

If you are a covered spouse of an employee covered by the Civil Service Bar Association Security Benefits Fund, you have the right to choose continuation coverage for yourself if you lose Supplemental health coverage under the Civil Service Bar Association Security Benefits Fund for any of the following qualifying events:

1) The death of your spouse;

2) The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;

3) Divorce or legal separation from your spouse;

4) Your spouse becomes entitled to Medicare after electing COBRA coverage; or

5) Your spouse's employer's commencement of a bankruptcy proceeding under the U.S. Bankruptcy Code.

In the case of a covered dependent child of an employee covered by the Civil Service Bar Association Security Benefits Fund, he or she has the right to continuation coverage if Supplemental health coverage under the Civil Service Bar Association Security Benefits Fund is lost for any of the following qualifying events:

1) The death of a parent;

2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;

3) Parent's divorce or legal separation;

4) A parent becomes entitled to Medicare after electing COBRA coverage;

5) The dependent ceases to be a "dependent child" under the Civil Service Bar Association Security Benefits Fund; or

6) The parent's employer's commencement of a bankruptcy proceeding under the U.S. Bankruptcy Code.

A newborn or adopted child will automatically be extended COBRA coverage if a parent already has COBRA coverage. This may involve an increase in the COBRA premium charged. In addition, a newborn child or an adopted child (or the child's custodian or guardian) may elect to continue COBRA coverage for up to 18 months or 36 months in accordance with the rules set forth below if the parent(s) are no longer entitled to COBRA. In effect, the newborn or adopted child has an independent right to continue for up to 18 or 36 months after the initial qualifying event.

Under the law, the employee or a family member has the responsibility to inform Fund Administrators of a divorce, legal separation, or a child losing dependent status under the Civil Service Bar Association Security Benefits Fund within 60 days of the later of the event or the date on which coverage would be lost because of the event. Your employer has the responsibility to notify the Civil Service Bar Association Security Benefits Fund within 30 days of the employee's death, termination of employment or reduction in hours, Medicare entitlement, or the employer's bankruptcy. **(However, we urge you — the employee or family member — to notify the Plan of any and all qualifying events.)**

When the Civil Service Bar Association Security Benefits Fund is notified that one of these events has happened, the Civil Service Bar Association Security Benefits Fund will, in turn, notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the later of the date you would lose coverage because of one of the events described or the date you receive this notice, to inform the Civil Service Bar Association Security Benefits Fund that you want continuation of coverage. You will have 45 days from the date you notify the Fund that you wish to purchase continuation coverage to pay your first month's premium.

If you do not choose continuation coverage, your group health insurance coverage will end. However, your other eligible dependents may elect the self-pay continuation coverage independent of your rejection.

If you choose continuation coverage, the Civil Service Bar Association Security Benefits Fund will give you coverage which, as of the time coverage is being provided, is identical to the coverage being provided by the Plan to similarly situated non-COBRA employees and family members.

If you are a covered employee or the dependent of a covered employee and you lost Supplemental health coverage because of termination of employment (for any reason other than gross misconduct) or a reduction in hours, you may purchase continuation coverage for up to 18 months from your last day of covered employment.

Individuals who are disabled on the date of their qualifying event or within 60 days thereafter, if that event was due to termination of employment or a reduction in hours, and who are determined to be eligible for a Social Security disability pension within 18 months of the qualifying event, may extend the maximum period of coverage for up to 29 months.

If any eligible beneficiaries (you, as a covered employee, your spouse, or any dependent child eligible for benefits) are entitled to Social Security disability benefits at the time of a qualifying event or within 60 days after a qualifying event, you may purchase an additional 11 months of COBRA as a disabled person (for a total of 29 months).

The additional 11 months of COBRA may be purchased not only for the disabled person but also for other covered family members who are not disabled (subject to the applicable premium).

To obtain the additional 11 months of COBRA coverage, the disabled person (employee, covered spouse or dependent child) must apply for

social security disability benefits before the end of the 18 month continuation coverage period and must notify the Fund Office within 60 days after the Social Security Administration awards Social Security benefits to the disabled person.

If another qualifying event occurs within 18 months after the termination of employment or reduction in hours, the required continuation coverage will be extended until 36 months after the termination of employment or reduction in hours. (This rule does not apply to an individual's reduction in hours that is a qualifying event followed by a termination of employment.) If you lost group health coverage for any other reason, you may maintain continuation coverage for up to 36 months.

Your continuation coverage will end for any of the following reasons:

1) Your employer no longer provides Supplement health coverage to any of its employees;

2) The premium for your continuation coverage is not paid within 30 days (45 days for the initial premium payment) of the due date;

3) You become covered under another health plan as an employee or otherwise that does not include a pre-existing conditions clause that applies to you or to a covered dependent; or

4) You became entitled to Medicare benefits after electing COBRA coverage.

The law says that, at the end of the 18, 29 or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion health plan if a conversion option is otherwise available to similarly situated individuals under the Civil Service Bar Association Security Benefits Fund.

If you have any questions about continuation coverage, please contact Amalgamated Employee Benefits Administrators, 333 Westchester Avenue, White Plains, NY 10604,
866-647-4617. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify Amalgamated Employee Benefits Administrators at the above address.

The Uniformed Services Employment and Reemployment Rights Act

If you stop working to enter Military Service, all benefits will terminate on the date you leave active employment. However, the Uniformed Services Employment and Reemployment Rights Act of 1994 enables you to continue your coverage for a period of time, and to be guaranteed reinstatement upon your return to work.

Continuation Coverage

Employees on uniformed service leave and their dependents who are covered by the Plan at the time leave begins may be eligible for continued health coverage while they are on leave for up to 18 months, beginning on the date on which the employee's absence for such leave commences. See "Your COBRA Rights" for more information on the availability of continuation coverage.

Reinstatement of Health Coverage

If your health coverage under the Plan is terminated by reason of service in the uniformed services, you are entitled to reinstatement of health coverage for yourself and your dependents upon your return to employment with your Employer, without the application of any waiting periods and pre-existing conditions limitations. The Plan may apply a waiting period or pre-existing conditions period for disabilities that the Veteran's Administration ("VA") has determined to be service connected. This includes any injury or sickness found by the VA to have been incurred in, or aggravated during, the performance of service in the uniformed services.

Honorable Discharge

All of the rights granted by the Uniformed Services Employment and Reemployment Rights Act of 1994 are dependent on uniformed service that ends honorably. Separation from the uniformed services that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in conviction under court martial, would disqualify a service member from any of the rights under the law.

Amendment/Termination Of The Plan

The Fund expects to continue this Plan indefinitely. The Trustees have the sole and absolute discretionary authority, however, to amend and modify the Plan (in whole or in part) at any time, and to change or discontinue the type and/or amount of benefits offered by the Plan and the rules for benefit eligibility, for any reason. The Plan may also be terminated if the obligation of all employers to contribute to the Fund ceases.

In addition, the Trustees retain the sole and absolute discretionary authority to interpret the terms of the Plan, determine benefit eligibility and resolve ambiguities or inconsistencies in the Plan.

Although Amalgamated Employee Benefits Administrators may administer the payment of claims, they do not insure or otherwise guarantee any of the benefits under the Fund.

Dental Program

The Dental Program is provided for full time members and part time members and their eligible dependents.

The Dental plan is administered through Self-Insured Dental Services (S.I.D.S), based on a schedule of payments.

The dental program offers two dental options:

- You may select one or more dentists from the listing of S.I.D.S' MetroDent Premier Participating Provider Organization participating providers. These dentists agree to accept the schedule as payment in full for all covered dental services after the deductible is paid. A fee would be charged for any service provided which is considered a non-covered service. Contact S.I.D.S. at 516-396-5500 or 718-204-7172 for a listing of participating providers.
- You may utilize a dentist(s) of your choice. Upon receipt of a completed claim form, reimbursement will be made to you or you may assign benefits to your dentist for all services which are covered under the dental program.

Covered Expenses

Covered expenses include charges made by a dentist for the performance of dental services when the service is performed by or under the direction of a dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

A service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared;
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Maximum Amount Payable

There is a $2,500 maximum payment for each individual covered by the Plan per calendar year for dental services other than orthodontics.

There is a $1,650 lifetime maximum payment for surgical implants, except to the extent that such surgical implants are an "essential health benefit" under applicable provisions and regulations of the Patient Protection and Affordable Care Act.

Annual Deductible

Each individual covered under the Plan is subject to a $50 deductible, with a $100 maximum family deductible per calendar year. Orthodontic services are not subject to the deductible.

How Benefits Are Paid

After dental work is performed, send completed claim form to:

S.I.D.S. Dept. 33, P.O. Box 9005, Lynbrook, NY 11563

Claim forms are available from the Fund Office. All claims must be filed within 12 months of the date of service. Claims filed later than 12 months after the date of service may not be reimbursed. If you would like the payment made directly to your dentist, sign the "Assignment of Benefits" section on the claim form. Payment will be at the rate of 100% of the amounts listed in the Schedule of Covered Dental Expenses, not to exceed actual dentist charges.

Pre-treatment Authorizations

If you require substantial dental work be sure to have your dentist submit a pre-treatment authorization so you will know if you have an out-of-pocket expense at the onset of treatment. Pre-treatment authorizations are required for inlays, crowns, laminate veneers, bridges, dentures, periodontal surgery, or when expenses will exceed $300 in a 90 day period.

If you fail to comply with the pre-authorization requirements, you run the risk of your claim not being paid by the Fund.

Alternate Benefit Provision

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could provide a suitable result based on accepted dental standards. In these instances, S.I.D.S. will determine the alternate course of treatment on which payment will be based and the expenses that will be included as covered expenses. You may elect to follow the original course of treatment and be responsible for charges which exceed Plan allowances for alternate treatment.

Limitations

Examination - two in a calendar year
X-ray - $90 maximum per calendar year
Prophylaxis - two in a calendar year
Replacement of crowns, bridges and dentures - not more than once in 5 years
Palliative treatment - no other treatment given that same visit
Topical fluoride treatment - to age 19, 1 application per year
Root scalling, curettage, bite correction, any combination - $204 in a calendar year
Sealants - per application per permanent unrestored molar for children under age 19
Denture adjustment - one in a calendar year
Orthodontic treatment - maximum 24 months for non-medically necessary pediatric orthodontia and adult orthodontia; limited to eligible

dependent children and medically necessary for adults. 'Pediatric' means services for dependents under age 19
Specialist Consultation - includes allowance for examination, maximum two per calendar year.

Extension Of Benefits

An expense incurred in connection with a dental service that is completed after a person's benefits cease will be deemed to be incurred while that person was eligible if:

- for crowns, inlays, fixed bridgework and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after the date the pre-treatment authorization was issued;
- for root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within one month after that person's eligibility terminated.

There is no extension for any dental service not shown above.

Expenses Not Covered

Covered expenses will not include, and no payment will be made for expenses incurred for:

- cosmetic restoration
- replacement of a lost or stolen appliance
- replacement of a bridge, crown or denture within five years after the date it was originally installed
- any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards
- procedures, appliances or restorations (except full dentures) whose main purpose is to:
  (a) change vertical dimension, or
  (b) diagnose or treat conditions or dysfunctions of the tempor mandibular joint, or
  (c) stabilize periodontally involved teeth
- multiple bridge abutments
- dental services that do not meet common dental standards
- services that are provisional or temporary
- services not included as covered dental services in the Civil Service Bar Association Dental Schedule
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- for or in connection with a sickness which is covered under any workers' compensation or similar law
- for charges made by a hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any insurance
- to the extent that payment is unlawful where the person resides when the expenses are incurred
- for charges which would not have been made if the person had no insurance, including services provided by the member's spouse
- to the extent that they exceed the amounts shown in the schedule of allowances
- for charges for unnecessary care, treatment or surgery
- to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program
- for or in connection with experimental procedures or treatment methods
- for or in connection with an injury caused by an accident covered by an automobile no-fault or financial responsibility law.

Claim Submission

You may use computer generated or universal claim forms, however, signature on file and signature trips are not acceptable. For more information contact S.I.D.S. at 516-396-5500.

Mail claims to:

Self Insured Dental Services
P.O. Box 9005, Dept. 33
Lynbrook, NY 11563

Claim forms are available at Amalgamated Employee Benefits Administrators.

Schedule

Diagnostic Services	Plan Pays
Oral Examination	40.00
Periodic Oral Examination	30..00
maximum two in a calendar year	
Full Mouth Series X-Rays	51.00
10 to 14 periapical & bitewing films	
Panoramic Film	51.00
Intraoral Film	
periapical or bitewing-each film	5.00
X-ray maximum-$90 per calendar year	
Occlusal Film	10.00
Extraoral-each film	25.00
posterior-Anterior, Lateral Film	20.00
Saliography	40.00
TMJ Film	20.00
Cephalometric Film	40.00
Pulp Vitality Test	15.00
Diagnostic Casts	25.00
Palliative Treatment	32.00
no other treatment that same visit	
Preventive services	
Prophylaxis	
Adult	35.00
Child	32.00
including scaling & polishing	
maximum-two ier calendar year	
Fluoride Excl. Prophy	28.00
to age 19, maximum one application per year	
Sealant	15.00
to age 19, per application per molar	
Space Maintainer	231.00
Restorative Services	
Silver Amalgam Fillings	
one surface	45.00
two surfaces	55.00
three surfaces	60.00
four or more surfaces	65.00
Sedative Filling	19.00
Composite Resin Fillings	
one surface	50.00
two surfaces	60.00

Restorative Services (contd.)	Plan Pays
three or more surfaces	75.00
incisal edge	80.00
Composite Inlay	
one surface	75.00
two surfaces	100.00
three surfaces	125.00
Ceramic Inlay	
one surface	200.00
two surfaces	230.00
three surfaces	275.00
Metallic Inlay	
one surface	225.00
two surfaces	275.00
three surfaces	300.00
Pin Retention-Per Tooth	25.00
Crowns	
acrylic jacket, laboratory	175.00
porcelain jacket	350.00
resin fused to metal	375.00
full cast & 3/4 cast	350.00
porcelain fused to metal	425.00
Porcelain Laminate Veneer, Lab	250.00
Prefab SS Crown-primary tooth	115.00
Post & Core, pre-fabricated	95.00
Post & Core, laboratory cast	125.00
Prosthodontics	
Complete Denture	
immediate or permanent	600.00
Partial Denture-unilateral	200.00
Partial Denture-bilateral	
acrylic base	425.00
cast metal base	600.00
Reline Denture-chair side	100.00
Reline Denture-lab	175.00
Bridge Abutments	
inlay-two surface	275.00
inlay-three surface	300.00
porcelain fused to metal	425.00
resin fused to metal	375.00
full cast and 3/4 cast	350.00

Prosthodontics (contd.)	**Plan Pays**
Bridge Pontic	
porcelain fused to metal	425.00
Precision Attachment	125.00
Recement Bridge	42.00
Recement inlay or crown	42.00
Repair Comp Dent Base	90.00
Replc Miss/Brkn TTN-Com Dent	85.00
Repair Part Acrylic Saddle/Base	90.00
Repair Cast Framework	100.00
Repair or Replace Crown Facing	100.00
Denture Adjustment	35.00
Oral Surgery	
Simple Extraction	55.00
Surgical Extractions	
must be demonstrated by pre-operative x-ray	
surgical extraction	85.00
soft tissue impaction	115.00
partial bony impaction	185.00
complete bony impaction	225.00
root recovery	100.00
Surgical Exposure Imp/Unerup	80.00
Surgical Exp Imp/Unerup-Ortho	160.00
Removal Of A Cyst	
<1/2 inch in diameter	75.00
>1/2 inch in diameter	125.00
Alveoplasty per quad	125.00
Incision & Drainage	50.00
Endosseous Implant per fixture	550.00
Subperiosteal Implant	550.00
Biopsy or Oral Tissue	75.00
Removal of Frenum	95.00

Periodontic Services

Although eight teeth constitute the anatomic compliment of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

	Plan Pays
Root Scaling & Gingival Curettage,	
Bite Correction, including prophylaxis	
per visit	51.00
full mouth	98.00
perio maintenance procedure	98.00
maximum allowance on any combination of the above services-$204 per calendar year	
Periodontal Surgery	
confirmation by charting and/or x-rays required per quadrant of at least 5 teeth	
Gingivectomy-per quad	175.00
Osseous Surgery-per quad	425.00
Osseous Graft-per site	90.00
Osseous Graft-per quad	250.00
Occlusal Adjustment-Complete	98.00
Occlusal Adjustment-Limited	51.00
Free Soft Tissue Graft-per quad	250.00
Endodontics	
x-ray of satisfactory completion required	
Pulp-Cap, direct	19.00
Vital Pulpotomy	60.00
Root Canal Therapy	
one canal	250.00
two canals	300.00
three canals	375.00
four canals	400.00
Apicoectomy, 1st root	175.00

Endodontics (contd.)	**Plan Pays**
Apicoectomy, maximum per tooth	350.00
Root Resection/Hemisection	150.00
Retrograde Root Filling	85.00
Adjunctive Services	
General Anesthesia	
plan pays 1st 30 min. only	150.00
Specialist Consultation	50.00
maximum two in a calendar year	
Therapeutic Injection	19.00
Orthodontic Services	
Diagnosis & Initial Appliance	600.00
Active Treatment, per month (maximum 24 months for non-medically necessary pediatric orthodontia and adult orthodontia)	75.00
Passive Treatment, per 3 months (maximum 3 visits for non-medically necessary pediatric orthodontia and adult orthodontia)	75.00
Post-Txstabilization Device	175.00

Localized delivery of Chemo-Therapeutic Agents (such as Perio-Chip Implants) annual allowance five per year, $35.00 per tooth. Annual maximum $175.00.

Prescription Drug Plan

The Prescription Drug Plan is provided for full time members and their eligible dependents. Part time members and their dependents are not covered.

How The Plan Works

The Prescription Drug Plan is administered by Teamsters Local 237 Welfare Fund. All active full time members receive one plastic prescription drug identification card per family.

When you need to have a prescription filled or refilled, present your prescription drug identification card to a participating pharmacy. As long as you use a participating pharmacy, all you have to pay is a copayment amount, regardless of the total cost of the prescription or refill.

Deductible:

$100 calendar year deductible per adult (dependent children waived).

Copayments:

- If a prescription or refill is dispensed using a generic drug the copayment is 5% of the cost of the prescription.
- If a prescription or refill is dispensed using a preferred brand name (formulary) drug the copayment is 15% of the cost of the prescription.
- If a prescription or refill is dispensed using a non-preferred brand name (non-formulary) drug, the copayment is 50% of the cost of the prescription.

The Plan covers for all generic/Brand Oral Contraceptives, contraceptive patches, Nuvaring and oral emergency contraceptives at the generic copay.

The drug plan allows you to receive up to a 30-day supply at Retail. However, you will be able to obtain up to a 90-day supply of a maintenance medication from CFI, the Plan's mail order pharmacy.

Mail order pharmacy copayments are as follows: a 5% copayment of the cost for generic drugs, a 15% copayment of the cost for preferred brand name drugs, and a 50% copayment of the cost for non-preferred brand name drugs for each prescription or refill ordered through Central Fill. A maximum 90-day supply will be dispensed.

Please note that for certain prescription drug claims, prior authorization or precertification may be required by Aetna before a prescription is filled. To find out if a prescription drug requires such prior authorization or precertification by Aetna, please contact Aetna Rx Member Services at (855) 352-1599.

If your pharmacy is non-participating, either contact Amalgamated Employee Benefits Administrators for a participating pharmacy in your area or pay for your prescription in full and you will be reimbursed through the

drug plan on a direct payment basis. Direct reimbursement can be more costly. If you are unable to use your card or have forgotten your card when filling a prescription, either you or your pharmacy should contact Teamsters Local 237 Welfare Fund or Amalgamated Employee Benefits Administrators immediately. There are steps which can be taken to assist you in acquiring the medication without having to submit on a direct reimbursement basis at a higher out-of-pocket cost. To receive direct reimbursement claim forms, contact Amalgamated Employee Benefits Administrators.

Covered Items

- Federal Legend Drugs (including oral contraceptives)
- State Restricted Drugs
- Compounded Prescriptions
- Prescription Birth Control
- Diabetic Pills
- Asthma Drugs
- Psychotropic Drugs

Rx OTC Program
If you currently take a prescription medication for stomach acid relief, or for allergy symptoms, there are alternatives that can save you money. Your prescription benefit covers two over-the-counter (OTC) products 1) Alavert and 2) Prilosec OTC **at no cost to you**. There products are equally safe and effective alternatives to similar prescription only medication. As well as, the Wise Choice Rx Program, which analyzes your prescription and helps you optimize your out of pocket costs. For more information on these programs, please contact Amalgamated Employee Benefits Administrators at (866) 647-4617 or Teamsters Local 237 Welfare Fund at (212) 924-7220 .

Proton Pump Inhibitor (PPIs) - Implement prior authorization program for all prescriptions within the therapeutic drug class.

All participants presenting a new or existing (refill) prescription for a brand name PPI class drug at the pharmacy will be subject to a Prior Authorization process.

Prior Authorization Criteria
To receive or continue receiving coverage for a brand name PPI drug, all participants must submit a prior authorization form signed by their physician stating that they have been medically diagnosed with ***Gastro Esophageal Reflux Disease (GERD)***.

PPI Class Drugs (Brand Names)

Nexium	Prevacid	Aciphex
Prilosec	Protonix	Zegerid

First Line Generics

Omeprazole	(generic of Prilosec)
Prilosec OTC	(generic of Omeprazole)

Note: Failure to have an approved Prior Authorization form on file will preclude approval for brand name medications. Members are encouraged to contact their physicians to obtain a prescription for a first line generic.

Sleep Aids Quantity Limits
Based on FDA Guidelines sleeping aids will be limited to 10 pills/month

Statins - We will provide free generic drugs for the cholesterol lowering medications **(Statins)** (Deductible is waived)

All participants presenting a new prescription for a listed brand name "Statin" class drug will be subject to a mandatory step therapy program. This program consists of participants that begin a drug regimen with a generic drug or have used a first line generic within the previous 90 days to utilize a second generic drug before the plan covers for a brand name. The initial utilization of first line generics will be available **at no cost** to the participants. This Step Therapy/prior authorization will not apply to new prescriptions presented for Lipitor 80mg. notwithstanding the above; the participant may receive the prescribed brand product if he/she meets the **Exemption Criteria** below.

Statin Drugs:
Brand Names

Lipitor	Crestor	Lescol
Prevachol	Mevacor	Zocor

First Line Generics:

Lovastatin	(Generic of Mevacor)
Pravastatin	(Generic of Pravachol)
Simvastatin	(Generic of Zocor)

Exemption Criteria
All participant that have had any of the following conditions or procedures, as documented by a licensed practitioner on a prior authorization form, are exempt from all step therapy guidelines:

- Acute Coronary event
- Angioplasty
- Stroke

OR

All participants that have used two different first line generics within a 12 month period are considered to have fulfilled step therapy/prior authorization requirements.

Exclusions

The following items are not covered:

- Fertility Drugs (with the following exception: Fertility drugs are covered only for the maintenance of a pregnancy.)
- Items lawfully obtainable without prescription

- Syringes and Needles (covered through NYC Contract)
- Devices and Appliances
- Insulin, Diabetic Agents (covered through NYC Contract)
- Chemotherapy Drugs (covered through NYC Contract)
- Prescriptions covered without charge under Federal, State, or Local Programs, to include Workers" Compensation
- Any charge for administration of a drug
- Investigational or experimental drugs
- Unauthorized refills
- Immunizational agents, biological sera, blood or plasma
- Medication for an eligible person confined to a rest home, sanitarium, extended care facility, hospital, etc.
- Any charge where the usual and customary charge is less than the Plan's deductible
- Any charge above the usual and customary, advertised or posted price, whichever is less than the scheduled amount
- Genetically Engineered Drugs (e.g. Protropin)

Effective July 1, 2001, the Citywide PICA Drug Program was established. For more information, please visit the Office of Labor Relations at http://www.nyc.gov/html/olr/html/home/home.shtml.

IMPORTANT — DRUGS COVERED UNDER THE PICA PROGRAM ARE NOT COVERED UNDER THE CIVIL SERVICE BAR ASSOCIATION PROGRAM.

Copayment Exceptions

Can you get a non-formulary drug at a formulary copayment?

If your physician concludes that for medical reasons you are unable to take the formulary drug, he/she can call Teamsters Local 237 Welfare Fund at (212) 924-7220. If authorization is granted, you will be able to fill the prescription in question at the preferred copayment (15%).

IMPORTANT – Through the joint efforts of the City of New York Office of Labor Relations and the City's Unions, represented by the Municipal Labor Committee, please take note of the following:

- Birth Control prescription and other preventive prescriptions will be covered by GHI CBP/HIP HMO Medical Plan. Please visit emblemhealth.com/city for a full list of preventive services.
- Drug coverage for opioid addiction treatments –EmblemHealth now covers for medicines used to treat substance-use disorders. This includes medicines usually prescribed for opioid addiction and dependence. These medicines, along with counseling and behavioral therapies, can successfully treat these disorders and help with recovery. Visit emblemhealth.com/OpioidAddictionTreatment for a list of covered medicines.
- Diabetic prescriptions and supplies as mandated by NYS are now covered by the health insurance carrier. All Rx's should be using the GHI or HIP card. For more information please call Express Scripts at 877 534-3682.

Life-Style Benefit

The Life-Style Benefit is provided for full time members and their eligible dependents. Part time members and their dependents are not covered.

Effective 2/1/2017 all Life –Style benefit (Sexual dysfunction drugs) will be covered through the PBM Aetna. The first $200 per family will be covered at 100%. 5% copay will apply after the first $200 of the benefit. No deductible.

Please note that because Aetna processes all Life-Style Benefit prescription drugs as of 2/1/2017, a 5% copay will be applied to all prescriptions at the time of purchase. To receive full coverage for the first $200 of Life-Style Benefit drugs each calendar year, please submit itemized receipts showing your copay costs for Life-Style Benefit drugs, for up to a $10.00 reimbursement per year from Amalgamated Employee Benefits Administrators. You may submit your receipts to Amalgamated Employee Benefits Administrators throughout the year as soon as you or your covered dependents incur $10.00 in copay costs per calendar year for a Life-Style Benefit drug.

Newborn Benefit

The Newborn Benefit is provided for full time members. Part time members and their dependents are not covered.

A benefit of $500 will be awarded for the birth of a child or the legal adoption of a child up to 18 years of age.

It is not necessary to prove out-of-pocket expense. It is only necessary to submit a completed claim form to Amalgamated Employee Benefits Administrators which must be accompanied by the child's birth certificate or certificate of adoption.

Under the provisions of the Fund, a member is eligible for this benefit as long as the member is in covered employment at the time the claim for benefits is incurred. A member is considered in covered employment if the Fund receives the monthly contribution due for that member from the City of New York. If a member is on a medical leave, the City is not obligated under the Family Medical Leave Act to continue contributions on behalf of that member.

If the city ceases making contributions for the member prior to the birth of the baby, no benefit is payable.

The 24 Hour Nurse HelpLine

This Program is provided for full time members and part time members and their eligible dependents.

The 24-Hour Nurse HelpLine is a service that allows you and your family to call registered nurses, toll free, 24 hours a day, who will assist you with your health questions. This is a completely voluntary program of health education, support

and counseling. In addition to speaking with a nurse, callers may choose to listen to any of over 1000 pre-recorded tapes dealing with a wide range of medical topics, such as allergies, diet, children's health and development, HIV/AIDS, cancer, exercise, dental health, drug abuse, and many other topics. Close to 600 of these tapes are also available in Spanish. Call the Nurse HelpLine at **1-800-557-6796.** The group access code is **1048.** See your Nurse HelpLine booklet for more information.

This service for members and dependents is for informational purposes only. You cannot file a claim on the HelpLine.

Hearing Aid Benefit

A Hearing Aid Benefit is provided for full time members and their eligible dependents. Part time members and their dependents are not covered.

Coverage is provided for up to $3,000 per device, total benefit payable for devices in both ears is $6,000 and up to $250 per mold per person, once every three years.

If you or an eligible dependent require a hearing aid:

- Contact Amalgamated Employee Benefits Administrators at 866-647-4617 to request a Hearing Aid Benefit Form;
- Submit the claim to your medical carrier first;
- Return the completed form to Amalgamated Employee Benefits Administrators along with:
    1. A doctor's prescription,
    2. A copy of your Explanation of Benefits from your medical provider,
    3. An invoice indicating that purchase was made and "paid in full".

Optical Benefit

The Optical Benefit provides full or partial payment for an eye exam and/or one pair of eyeglasses/contact lenses for full time members and their eligible dependents and for part time members, once per calendar year.

Contact Amalgamated Employee Benefits Administrators at 866-647-4617 or e-mail CSBAinfo@AmalgamatedBenefits.com prior to your appointment to request an optical voucher or if you have any questions.

You may choose one of the following options:

- You may use your own optometrist.

  If you elect to use an optician/optometrist of your choice, the voucher will entitle you to up to a $150 reimbursement for glasses and/or exam or contact lenses and/or exam. An itemized sales receipt must be attached to the completed voucher when submitting for reimbursement.

OR

- You may use a participating provider.

  A list of participating providers will be sent to you with your optical voucher. These vendors provide a selection of private optical centers in many convenient New York locations as well as out of state locations. In addition to an eye examination, a selection of lenses with tint, oversize, as well as an array of boutique frames from which to choose are also available. Additional discounts are available on non-covered items.

GHI Subscribers

IMPORTANT: If you are a GHI subscriber and utilize a GHI participating physician, the cost of your exam will be excluded from your benefit. If you are a GHI subscriber and utilize a non-GHI provider, you must first submit your claim to GHI. Attach a copy of the GHI Explanation of reimbursement. The benefit paid by GHI will be deducted from the amount you claim.

VDT Program

Civil Service Bar Association members may also be eligible for an additional exam and/or glasses or contacts every 24 months from NYC's VDT program if he or she uses a video display terminal for more than 20 hours a week. A participating optician must be used for this service. New York City Transit Authority employees are <u>not</u> eligible for the VDT program.

Please contact Amalgamated Employee Benefits Administrators for further information or to acquire a voucher and a list of participating providers.

Short Term Disability Coverage

Coverage is provided for full time members. Dependents and part time members are not covered.

The short term disability benefit is insured with Unum Provident.

Eligibility

If an illness, pregnancy or accidental injury makes you unable to perform the duties of your job, the Plan provides coverage for weekly disability income.

To be eligible you must be:

- receiving appropriate care and treatment from a doctor on a continuing basis, and
- unable to earn more than 80% of your pre-disability earnings at your own occupation for any employer in your local economy.

How Much Can You Receive And For How Long?

Weekly disability income is 50% of your gross weekly earnings, less income from other sources, to a maximum payment of $300 a week for a maximum of 13 weeks.

When Payments Begin

You will become entitled to payment after 14 days of continuous disability or when any accumulated sick leave is used, whichever is longer.

How to File a Disability Claim

Claim forms are available from Amalgamated Employee Benefits Administrators at 866-647-4617. Claims must be filed within three months of the onset of your disability. Claims submitted after that period may be denied for late filing.

The Fund is aware that you need your weekly disability income to replace your lost wages, and makes every effort to process your claim as quickly as possible. You can help speed the processing of your claim if you:

- Follow the instructions on the claim form carefully and make sure everything is properly completed.
- Make sure your employer completes the earnings section on the claim form.

- Make sure your doctor fills out the medical section completely. If you have to leave the form with your doctor, follow up to see that it is mailed promptly.

Claim denials may be appealed. See the section titled "Your Right To Appeal."

Exclusions

You cannot receive disability payments:

- unless you are under the care of a doctor during the period you are unable to work,
- for any period of time you are not considered disabled according to the Fund's guidelines,
- if your disability results from or occurs during the commission of a crime or illegal act by you,
- during a period for which you received or are eligible for Unemployment Insurance Compensation,
- if your disability results from an act of war, whether declared or undeclared, or caused during service in the armed forces of any country,
- if your disability is due to an illness or injury arising out of or in the course of your employment.

A booklet is available from Amalgamated Employee Benefits Administrators describing this benefit in greater detail.

Long Term Disability Coverage

Coverage is provided for full time members. Dependents and part time members are not covered.

The long term disability benefit is insured with Unum Provident.

Eligibility

If an illness, pregnancy or accidental injury makes you unable to perform the duties of your job, the Plan provides coverage for long term disability income.

To be eligible you must be:

- receiving appropriate care and treatment from a doctor on a continuing basis, and
- completely and continuously unable to perform each of the duties of your regular job. After the first 24 months of benefit payments, you must also be completely and continuously unable to perform the duties of any gainful work or service for which you are reasonably qualified taking into consideration your training, education, experience and past earnings.
- You are considered totally disabled when, due to an injury of sickness, you suffer a 50% loss of earnings capacity and require the regular care and attendance of a doctor.
- Maternity claims would be covered if you become disabled as a result of pregnancy complications or other illness.

Pre-Existing Condition Limitation

This Plan does not provide benefits for any total disability that is caused by or contributed to by, a pre-existing condition unless the total disability begins after you have been covered under this Plan for 12 consecutive months.

How Much Can You Receive?

Weekly disability income is 50% of your gross monthly earnings, less income from certain other sources (see Plan booklet for details), to a maximum payment of $3,000 per month (minimum monthly benefit is $100).

When Payments Begin

You will become entitled to payment after 90 days of continuous disability or when any accumulated sick leave is used, whichever is longer. For

example, if you have accrued 100 days of sick leave, the plan will not pay from the 90th day to the 100th day. Benefits would commence on the 101st day.

When Payments End

The monthly benefit will end on the earliest of:

- the date you cease to be totally disabled,
- the date of your death,
- completion of the maximum benefit duration.

Maximum Benefit Duration:

Age When Total Disability Begins	Benefit Duration
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Survivor Benefit

If you die after total disability has continued for at least 12 months and while a monthly benefit is payable, your eligible survivor will be paid a monthly income benefit equal to 2/3 of your last monthly benefit for a period of three months from the date of your death.

How to File a Disability Claim

Claim forms are available from Amalgamated Employee Benefits Administrators at 866-647-4617. Claims must be filed within six months of the onset of your disability. Claims submitted after that period may be denied for late filing.

Claim denials may be appealed. See the section titled "Your Right To Appeal."

Exclusions

You cannot receive disability payments:

- unless you are under the care of a doctor during the period you are

unable to work,
- for any period of time you are not considered disabled according to the Fund's guidelines,
- if your disability results from or occurs during the commission of a crime or illegal act by you,
- during a period for which you received or are eligible for Unemployment Insurance Compensation,
- if your disability results from an act of war, whether declared or undeclared, or caused during service in the armed forces of any country,
- if your disability is due to an illness or injury arising out of or in the course of your employment.

A booklet is available from Amalgamated Employee Benefits Administrators describing this benefit in greater detail.

Life Insurance Coverage

Life Insurance covers full time and part time members lives. Dependents are not covered.

The life insurance benefit is insured with Amalgamated Life Insurance Company.

The Amount Of Your Life Insurance

If you are actively working on or after January 1, 1997, your life is insured as follows:

- Up to age 65.....$25,000
- Ages 65 through 69.....$5,000
- Ages 70 and over.....$1,000 (Self Insured)

From the first through the twelfth month of employment, the amount of your life insurance will be half of the above amount. You will then be covered for the full amount.

Your Beneficiary

You name your beneficiary when you complete your enrollment form and file it with Amalgamated Employee Benefits Administrators. To change your beneficiary, obtain a change of beneficiary form from Amalgamated Employee Benefits Administrators, fill it out and return it. A change of beneficiary does not take effect until a signed form, authorizing the change, is received by Amalgamated Employee Benefits Administrators.

If you name more than one beneficiary, you may specify different amounts to be paid to each. If you don't specify, your beneficiaries will receive equal shares of your life insurance.

If a beneficiary does not survive you, or if there is no beneficiary, that share of your life insurance will be paid according to the following order:

- spouse
- children
- parents
- brother(s) and sister(s)
- the administrator of your estate.

How Payment Is Made

A lump sum will be paid to your beneficiary. If your beneficiary is a minor or a person who cannot handle his/her own affairs, payment will

be made to a legally appointed representative.

If there is no legal representative, the minor's share will be held by the Company until the minor reaches the age of majority. At that time, the life insurance and any accrued interest will be paid to the beneficiary.

If no legal guardian is appointed for a beneficiary who cannot handle his/her own affairs, periodic payments may be made to those with responsibility for him/her.

How To Convert Your Life Insurance

If your group life insurance coverage ends, you will have the opportunity to convert your coverage to an individual policy. An individual policy is available in an amount equal to your group policy. You will not be required to take a medical exam. When you purchase an individual policy, the premium payments will be based on your current age. If you choose to convert your group insurance, you must do so within 45 days of the termination of your active status.

To obtain a conversion application, contact Amalgamated Employee Benefits Administrators at 333 Westchester Avenue, White Plains, NY 10604, 866-647-4617.

GRANDFATHERED HEALTH PLAN NOTICE

This group health plan believes this plan is a "grandfathered health plan." As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Amalgamated Employee Benefits Administrators – 333 Westcherster Avenue, White Plains, NY 10604; Phone 866 647-4617. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]