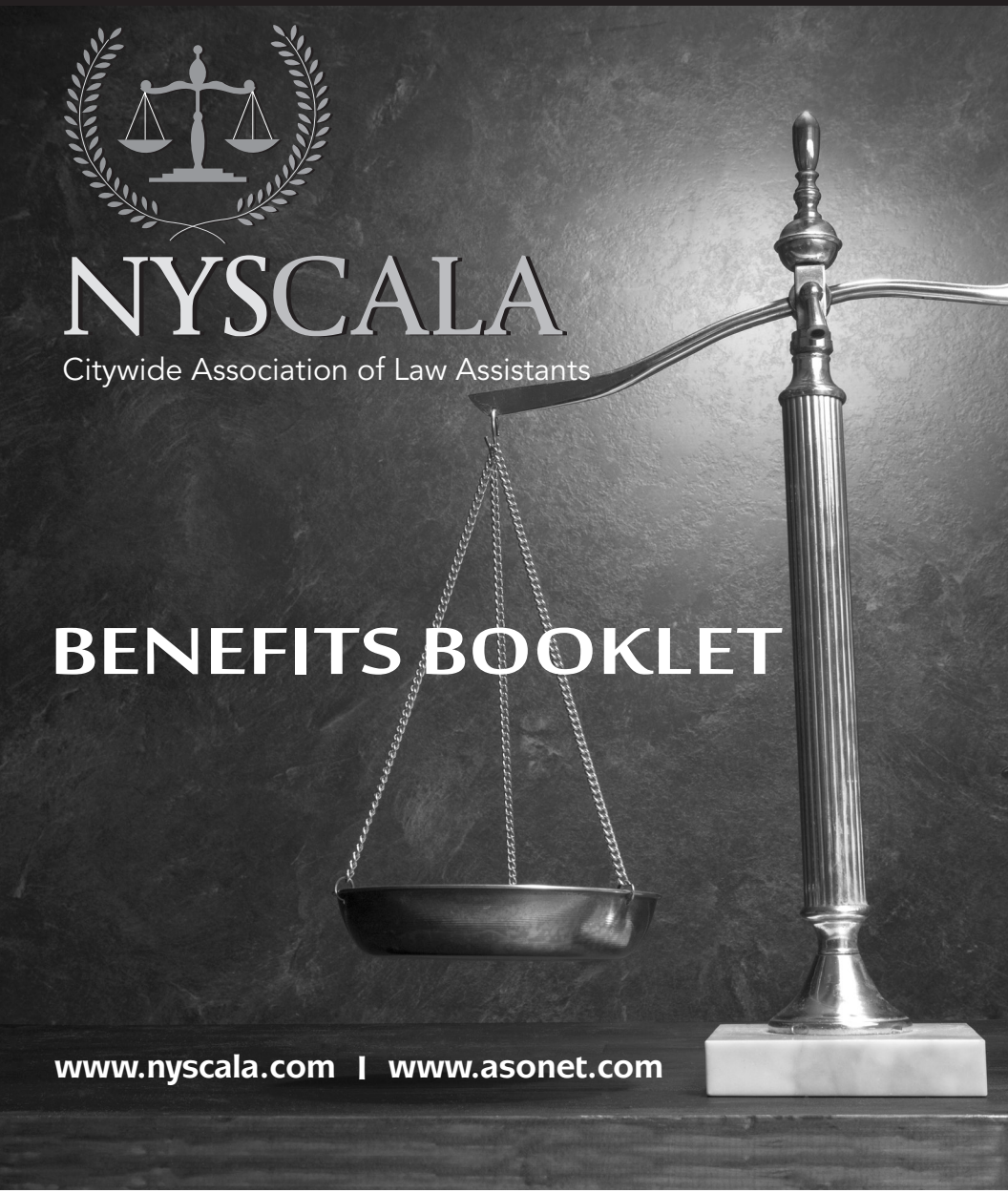

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Welfare Trust Fund

March 2016

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City Wide Association of Law Assistants

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

BENEFITS BOOKLET

www.nyscala.com
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March 2016

CITYWIDE ASSOCIATION OF LAW ASSISTANTS
OF THE CIVIL, CRIMINAL AND FAMILY COURTS
IN THE CITY OF NEW YORK WELFARE TRUST FUND

303 Merrick Road, Suite 300
Lynbrook, NY 11563

800.537.1238
516.396.5500
www.nyscala.com
www.asonet.com

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CONSULTANT

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AUDITOR

Rick Skutch, CPA

March 2016

To All Covered Members:

We are pleased to present this revised booklet containing important information regarding the recently improved benefit plan and administrative procedures.

The benefits outlined in this booklet are the current benefits. Since there have been changes in some of the benefits, please read this booklet carefully and show it to your family. Any future changes will be posted on the website, where you can always find the most current version of this booklet.

In order to obtain claim forms, please either visit **www.nyscala.com** or call the Fund office at **516.396.5500**.

We shall continue to monitor the experience of the Fund in order to provide you the most favorable plan of benefits within the framework of prudent fiscal operations.

We urge you to read this booklet thoroughly and keep it for future reference. Of course, if you have any questions, the Fund Office is ready to help you at all times.

Sincerely,

BOARD OF TRUSTEES

Barbara G. Brown

Myles Baer

Lisa Rosenzweig

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ELIGIBILITY

Who Is Eligible?

All full-time and part-time (half-time or more) employees of the Unified Court System in titles represented by the Citywide Association of Law Assistants of the Civil, Criminal and Family Courts in the City of New York (herein called "member") and your eligible dependents will become eligible on the date of your employment if the Unified Court System makes a contribution to the Fund on your behalf.

Part-time employees for whom the State of New York only contributes half the annual full-time, employee-required contribution to this Fund are eligible for half the benefits of full-time employees outlined in this booklet, except where otherwise stated.

Retirees who retired since April 1, 1977, while in a title represented by the Citywide Association of Law Assistants of the Civil, Criminal and Family Courts in the City of New York, and your eligible dependents, also are eligible for benefits, except educational benefits and benefits that are specific to active employees only.

Your **Eligible Dependents** include:

- A Spouse that is recognized as your Spouse by the state in which you reside
- A Domestic Partner as defined by the Plan
- A Dependent Child, which is any of the member's children listed below who are under the age of 26 (whether married or unmarried):
    - Son or daughter
    - Stepchild
    - Domestic partner's child
    - Legally adopted child or child placed for adoption with the member. Placed for adoption means the assumption and retention by the member of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.
    - Child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO).
    - Foster child lawfully placed with the member by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Except as provided below with respect to a disabled child, coverage shall terminate for a Dependent Child at the end of the month in which the dependent turns 26.

In addition to Dependent Children defined above, the following individuals are eligible for coverage under the Plan:

- An unmarried dependent child (as defined above) age 26 or older who is **permanently and totally disabled** with a disability that existed prior to age 19 and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively **and/or** who will be claimed as a dependent on the member's tax return for each plan year the coverage is provided. The Plan will require initial and periodic proof of disability.
- An unmarried individual under age 19 with respect to whom the member has **legal guardianship** under a court order (proof of guardianship and age will be required) and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively **and/or** who will be claimed as a dependent on the member's tax return for each plan year the coverage is provided. With the exception of a Dependent Child who is permanently and totally disabled prior to age 19, coverage shall terminate on the September 30th next occurring after the child's 26th birthday.

It is the **member's obligation** to inform the Plan promptly if any of the requirements set out in this definition of a Dependent child are NOT met with respect to any child for whom coverage is sought or is being provided.

If you and your spouse are both eligible Fund members, each of you may cover only yourself. You cannot elect individual coverage and also cover each other as dependents. If there are eligible dependent children, only one parent may cover them. The Fund will not, under any circumstances, make duplicate payments on a single claim.

Qualified Medical Child Support Orders (QMCSO)

If a court or a state administrative agency has issued an order with respect to the provision of health care coverage for any of your dependent children, the Fund Administrator or its designee will determine if the court or state administrative agency order is a Qualified Medical Child Support Order

(QMCSO) as defined by federal law, and that determination will be binding on the member. The state administrative agency order must be issued through an administrative process established by state law and must have the force and effect of law under the applicable state law.

An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not provide, or if it requires a member who is not covered by the Fund to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMCSO, and if the member is covered by the Fund, the Fund Administrator or its designee will so notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage of the dependent children. However, no coverage will provided for any dependent child under a QMCSO unless the applicable contributions for that dependent child's coverage are paid and all of the Fund's requirements for coverage of that dependent child have been satisfied.

Special Enrollment For Eligible Dependents

If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Family and Medical Leave (Also known as FMLA)

If you are entitled by law for up to 12 weeks of unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill, or for your own illness, you can continue your coverage during that leave period provided the Unified Court System is required to continue to pay contributions for your coverage during the period of that leave. If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation of Coverage, as described on page 9.

Questions regarding your entitlement to family and medical leave and the designation of your leave as such should be referred to the Office of Court Administration. Questions about the continuation of your coverage should be referred to the Fund Office.

Military Leave

If you go into active military service for up to 31 days, you can continue your coverage during that leave period. The Unified Court System must continue to pay your contributions for your coverage during that period of leave.

If you lose eligibility because of your induction into the Armed Forces, you will be reinstated for benefits as of the date of your re-employment with the Unified Court System, provided that you secure such employment within 90 days of your discharge from the service or within 90 days of hospital discharge if you are hospitalized at the time of your separation from the service. If you are called into active military service for more than 31 days, you may be able to continue your coverage at your own expense for up to 24 months through COBRA (see page 9).

Questions regarding your entitlement to this leave should be referred to the Office of Court Administration. Questions about the continuation of your coverage should be referred to the Fund Office.

WHEN BENEFITS TERMINATE

Your benefits terminate when you terminate employment unless you become a retiree under the State Pension System. Eligible retirees are eligible for benefits under the Fund as described in this booklet except for educational assistance and benefits specific to active employees, or in certain circumstances, if you are laid off by the Unified Court System. A dependent's coverage terminates when your coverage terminates or when that dependent is no longer an eligible dependent, whichever occurs first. However, you may self pay for continued coverage. See the following section entitled "COBRA CONTINUATION COVERAGE".

COBRA CONTINUATION COVERAGE

Under a Federal Law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") group health plans must offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage"), at group rates in certain instances where coverage under the Fund would otherwise end (called "qualifying events"). This section is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Fund. If you have additional questions regarding your rights under COBRA, contact the Fund Administrator at:

Citywide Association of Law Assistants Welfare Trust Fund
c/o Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563
800.537.1238
516.396.5500

If you are an **employee** of the Unified Court System in a title represented by the Citywide Association of Law Assistants and are covered by the Fund, you have a right to choose continuation coverage if you lose your group health coverage because of a reduction in your hours of employment that leaves you ineligible for coverage by the Fund or the termination of your employment for reasons other than gross misconduct on your part. Please remember that if you elect COBRA coverage under this Fund, the election applies only to this Fund. Your election with this Fund will not continue coverage of benefits provided elsewhere.

If you are the spouse of an employee covered by the Fund, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Fund for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct), or a reduction in your spouse's hours of employment with the Unified Court System;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare (Part A, B or both).

Dependent children of an employee covered under the Fund have the right to choose continuation coverage if group health coverage under the Fund is lost for any of the five following reasons:

1. The death of the employee-parent;
2. The termination of the employee-parent's employment (for reasons other than gross misconduct), or a reduction in the employee-parent's hours of employment with a Contributing Employer;
3. Parents' divorce or legal separation;
4. Employee-parent becomes enrolled in Medicare (Part A, B or both); or
5. The Dependent ceases to be a "dependent child" under the terms of the Fund.

A child who is born to or placed for adoption with a covered employee during the period of the employee's continuation coverage is a "qualified beneficiary" and generally is eligible to be enrolled immediately for COBRA continuation coverage under the plan. Once the child is enrolled pursuant to the Fund's rules, he or she will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the birth or adoption).

Giving Notice of Qualifying Events

Under the law, you or your family member have the responsibility to inform the Fund Administrator of a divorce, legal separation, or a child losing dependent status under the Fund within 60 days of the date of the qualifying event. **This notice must be in writing and must be sent to the Fund Administrator at the address at the beginning of this section.** The Unified Court System has the responsibility to notify the Fund Administrator of the employee's death, termination of employment, reduction in hours of employment, or Medicare entitlement (Part A, B or both).

How COBRA Coverage is Provided

When the Fund Administrator is notified that a qualifying event has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of (i) the date you ordinarily would have lost coverage because of one of the events

described above, or (ii) the date of the notice of your right to elect continuation coverage to inform the Fund Administrator that you want continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect continuation coverage on behalf of their spouse, and parents may elect continuation coverage on behalf of their children.

If you do not choose continuation coverage during this 60-day period, your group health insurance coverage under the Fund will end.

How Long Will Continuation Coverage Last?

If you choose continuation coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Fund to similarly situated employees (or their family members). Continuation coverage is a temporary continuation of coverage.

If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months. Please note that the periods described throughout this section are all measured from the date of the qualifying event. In the event you are called into military service for more than 30 days, coverage may be continued for 24 months. For military service of less than 31 days, health care coverage is provided as if the service member had remained employed.

Disability Extension of 18-month Continuation Coverage

An 18-month period of continuation coverage may be extended for up to 11 months (up to 29 months in total), if you or any other qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act). The disability would have to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The extension is provided not only to the disabled qualified beneficiary, but to any family member who is a qualified beneficiary in connection with the same qualifying event. The Fund will charge 150% of the cost of coverage during the 11-month disability extension. In order to receive this 11-month extension, you or your family member must notify the Fund Administrator within 60 days of such determi-

nation by the Social Security Administration (SSA) (and within the initial 18-month continuation coverage period). **This notice must be in writing and must include a copy of the disability award letter from the Social Security Administration. The notice of disability must be provided before the end of the first 18 months of COBRA coverage. Please send the notice to the Fund Administrator at the address at the beginning of this section.**

Second Qualifying Event Extension of 18-month Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund Administrator. This extension may be available to your spouse and dependent children receiving continuation coverage if you die, become enrolled in Medicare (Part A, B or both), if you and your spouse divorce or become legally separated, or if your dependent child stops being eligible under the Fund as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

When COBRA Coverage Ends

Your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

1. The Fund no longer provides group health coverage;
2. The premium for your continuation coverage is not paid on time;
3. The individual becomes covered under another group health plan (as an employee or otherwise) that (i) does not contain any preexisting condition exclusion or limitation applicable to the individual, or (ii) contains a preexisting condition exclusion or limitation, but it does not apply to the individual because he or she had at least 12 months of creditable health coverage that ended no more than 62 days before coverage under the new Fund began.
4. The individual becomes enrolled in Medicare (Part A, B or both); or
5. Coverage has been extended for up to 29 months due to disability and there has been a final determination by the SSA that the individual is

no longer disabled. You are required to notify the Fund Administrator within 30 days of any such final determination.

Once your continuation coverage terminates for any reason, it cannot be reinstated.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage by the Fund. The Board of Trustees reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible at that earlier time.

Cost of COBRA Continuation Coverage

Under the law, you may have to pay the premium for your continuation coverage. During the initial 18- or 36-month period of continuation coverage, you will have to pay 102% of the applicable premium for your continuation coverage. However, during the additional 11 months of continuation coverage for disability, the Fund will charge up to 150% of the applicable premium for such continuation coverage. In the event continuation coverage is extended to 36 months for a disabled qualified beneficiary who experienced a second qualifying event during the 11-month disability extension (described above), the Fund will require payment of up to 150% of the applicable premium until the end of the 36-month maximum coverage period. However, if the disabled qualified beneficiary experiences a second qualifying event during the original 18-month period of continuation coverage, the premium will be 102% of the applicable premium.

It is easiest to make your **first payment** when you file your COBRA election form. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check should cover the period from the date your group coverage ended and COBRA coverage began through the current month. All **subsequent payments** after the first payment will be due on the first day of each month for that month's coverage (for example, by June 1 for June coverage). Keep in mind that the Fund Office does not send monthly bills for COBRA coverage and it is your responsibility to see that your payment is at the Fund Office by the due date.

There is a **30-day grace period** for all subsequent payments (for example, the end of the grace period for payment for coverage in the month of June

is June 30). However, if you have a claim during a month for which you have not paid your premium, the claim will not be paid until after the Fund Office receives your payment for the month.

COBRA premiums are generally reviewed once a year and are subject to change. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) ("eligible individuals'). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1.866.628.4282. TTD/TYY callers may call toll-free at 1.866.626.4282. More information about the Trade Act is also available at **www.doleta.gov/tradeact/2002act_index.asp.**

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the U.S. Center for Medicare and Medicaid Services at phig@cms.hhs.gov or call toll free at 1-877-267-2323, option #4, extension 61565. For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Fund Informed of Address Change

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notice you send to the Fund Office.

COORDINATION OF BENEFITS ("COB")

Occasionally, a patient is entitled to receive benefits under this Plan and also will be eligible for similar benefits under another group health insurance plan. This is becoming more common as many households now contain two individuals who are employed and are covered under separate employee group health insurance plans. Since it is not intended that greater benefits be received than the actual expenses incurred, the amount of benefits available under this Plan will take into account any coverage a family member may be entitled to under another group health insurance plan.

If this happens, the two plans will coordinate their benefit payments so that the combined payments of both plans will not exceed the actual expenses incurred by the patient. One plan (the Primary Plan), will first pay its full benefits. The other plan (the Secondary Plan), will pay any expenses in excess of the benefits paid under the Primary Plan, up to the maximum amount that it would pay if the COB provision was not in effect.

The order of payment is determined by the rules promulgated by the National Association of Insurance Commissioners — the health plan of the parent whose birthday comes first in the calendar year will be considered the primary plan.

If you are covered as an employee or a dependent under another group health insurance plan that does not have a COB provision, that plan will be the Primary Payor of benefits.

If the patient is the employee under one group health insurance plan and a dependent under the other, then the plan under which the patient is the employee will be the Primary Payor of benefits.

If the patient is a dependent child under both plans, then the parent whose birthday is earlier in the year (month and day) will be the Primary Payor except if the parents are divorced or separated.

When a court decree has established which parent has financial responsibility for the child's health care expenses, that parent's plan will be the Primary Payor.

When financial responsibility has not been established, the plan that covers the child or a parent with legal custody will be the Primary Payor.

If none of the above apply, then the plan under which the patient has been covered the longest will be the Primary Payor of benefits.

If you are unable to determine which group health insurance plan is the Primary Payor of benefits, please contact the Fund Office for assistance.

CLAIMS FILING PROCEDURES

Filing

If a claim is for you or an eligible dependent and this Fund is the Primary Payor of benefits under the coordination of benefits system described above, you should file your claim form with this Fund Office. If the Fund is a Secondary Payor under the coordination of benefits system, you must first file your claim with the plan that is the Primary Payor of benefits. After the Primary Payor reimburses you for your expenses, an explanation of their benefit payment should be submitted to the Fund Office with the appropriate claim form and bill for service.

Where to Obtain Forms and File Claims

Claim forms may be obtained online at **www.nyscala.com** or **www.asonet.com** or by calling the Fund Office. Completed claim forms and the appropriate attachments (i.e., bill or service or explanation of benefits) should be sent to the Fund Office at the following address:

Citywide Association of Law Assistants Welfare Trust Fund
c/o Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563

You may call the Fund Office for information at 516.396.5500 or 800.537.1238, or obtain forms at www.nyscala.com or www.asonet.com.

When to File a Claim

You must file a claim as soon as you or your insured dependents incurs expenses for which the plan provides benefits, BUT NO LATER THAN 90 DAYS FROM THE DATE SUCH EXPENSES WERE INCURRED.

DENTAL BENEFIT PLAN

What are the Benefits?

This Dental Plan will pay a benefit up to the maximum allowances as shown in the Schedule of Covered Dental Expenses or the dentist's actual charges, whichever is less, subject to a $3,000 calendar year maximum per eligible person. Notwithstanding the above,

Part-time employees for whom the State of New York only contributes half the annual full-time employee required contribution to this Fund are eligible for half the benefits of the benefits stated in this section.

Retirees who, upon their retirement date, have less than one year of active employment in the CALA bargaining unit, and their dependents will only be reimbursed during the lifetime of the retiree at 50% of the scheduled rate of any dental procedure in this booklet's schedule. Dependents coverage will cease upon the death of the retiree.

You have the right to opt out of eligibility for dental benefits for yourself or your dependents if you so wish by notifying the Fund office.

Covered Dental Expenses

Covered Dental Expenses are the charges of a dentist that you are required to pay for services and supplies listed in the Schedule of Covered Dental Expenses (which begins on page 23) received in connection with a course of dental treatment by you or your dependents while covered by this Plan.

However, these allowances are only included as Covered Dental Expenses to the extent that the services, supplies, and course of treatment are medically necessary and appropriate for treatment. The total, currently existing oral condition of the individual receiving the treatment will be taken into consideration.

Furthermore, allowances for covered services and supplies will be considered as Covered Dental Expenses only to the extent the service or supply meets professionally recognized standards of quality and the service or supply is essential, and sufficient to produce a professional result.

If two or more dental services are rendered, payment will be made for each dental service unless the Schedule of Covered Dental Expenses specifies a maximum amount for a particular combination of dental services.

Covered dental expenses will include charges for the following, subject to plan provisions and limitations:

1. Replacement of an existing partial or full removable denture or fixed bridgework that replaces missing natural teeth by a new partial or full removable denture, or addition of teeth to an existing partially removable denture;
2. Replacement of existing, fixed bridgework that replaces missing natural teeth by new fixed bridgework or the addition of teeth to existing fixed bridgework; or
3. Replacement of an existing partial denture that replaces missing natural teeth by new fixed bridgework but only when, as a result of the existing condition of the oral cavity, a professional result can be achieved only with bridgework. Otherwise, the Covered Dental Expenses for the replacement of an existing denture are limited to the Covered Dental Expenses for a new denture;

The Covered Dental Expenses listed above will only be reimbursed for an eligible member or dependent when evidence is presented for the following conditions:

1. The replacement or addition of teeth is required to replace one or more missing natural teeth extracted or accidentally lost after the existing denture or bridgework was installed;
2. The existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be repaired, duplicated, or made serviceable; or
3. The existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture takes place within 12 months from the installation of the immediate temporary denture.

Benefits for the Replacement of, or Addition to, Prosthetic Appliances

Benefits are provided, under certain circumstances, for charges for the replacement of, or addition to, prosthetic appliances.

When to File a Claim

You must file a dental claim for Covered Dental Expense Benefits as soon as you incur, or one of your insured dependents incurs, expenses for which the Dental Expense Benefits plan provides benefits, BUT NO LATER THAN 90 DAYS FROM THE DATE SUCH EXPENSES WERE INCURRED.

Exclusions

Conditions under which Fund Coverage for Dental Expenses of any kind are excluded from reimbursement are:

1. Charges for treatment not made by a dentist, except cleaning or scaling of teeth performed by a licensed dental hygienist, if such treatment is rendered under the supervision and direction of a dentist;
2. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures;
3. Charges for replacement of an inlay, onlay, crown, dentures, bridgework, or other prosthetic appliances within five years after the date they were originally installed;
4. Charges for crowns, inlays, onlays, dentures, bridgework, or other prosthetic appliances and the fitting thereof which were ordered while the individual was not covered under this Plan but are finally installed or delivered to such individual more than 30 days after termination of coverage;
5. Charges for the replacement of a lost or stolen prosthetic device;
6. Charges for any services or supplies that are for the correction or modification of the occlusion, including orthodontic treatment, except to the extent that benefits are provided for in the Schedule of Benefits for Covered Dental Expenses;
7. Charges for any duplicate prosthetic device, or other duplicate device or appliance;
8. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances to increase vertical dimension;
9. Charges for precision or other elaborate attachments or features for dentures, bridgework, or any other dental appliances;

10. Charges for any services or supplies not specifically included as Covered Dental Expenses;
11. Charges that would not have been made if no insurance existed or charges that neither you nor any of your dependents are required to pay;
12. Charges for services or supplies furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government;
13. Charges for services or supplies paid for or otherwise provided for under law of a government (national or otherwise) except where the payments or benefits are provided under a plan specifically established by a government for its civilian employees and dependents;
14. Charges for any dental treatment, services, or supplies not recommended and approved by the attending dentist;
15. Charges for services or supplies that do not meet professionally recognized standards of quality, are not necessary for treatment of existing disease or injury, or are not appropriate treatment, taking into account the total currently existing oral condition;
16. For, or in connection with, services or supplies resulting from an accidental injury and are deemed to be the responsibility of a third party;
17. For or in connection with a sickness or injury arising out of, or in the course of, any employment for wage or profit that is covered under any Workers' Compensation, occupational disease, or similar law;
18. For a sickness or injury that is the result of war, declared or undeclared, or any act of war or aggression;
19. For an injury that is the result of participation in a felony, riot, or insurrection; or
20. For or in connection with experimental procedures or treatment methods not accepted.

Metrodent Premier Panel of Participating Dentists

This feature of your Dental Plan is designed to substantially reduce or eliminate the non-reimbursed portion of your dental bill. Since usual and customary dental charges generally exceed Dental Plan reimbursements when you use a non-participating provider, using a Participating Metrodent Dentist may provide you with a significant savings in the cost of your dental care.

When you use a participating provider you will not incur any out-of-pocket expenses except in the following instances:

- For services that are listed in the Schedule but for which the Plan will not pay. For example, procedures may be denied due to frequency limits or maximums. Even in this instance, however, the participating dentist's charges may not exceed the Maximum Charges as stated in the Schedule.
- For non-covered services (there are a few procedures not covered by the Plan; please refer to your benefits booklet), you are not to pay more than the dentist's usual and customary charge for that service.

The Directory of Participating Dentists includes the names, addresses, and telephone numbers of General Practitioners, Periodontists, Endodontists, Oral Surgeons, and Orthodontists. You should be aware that although several dentists may practice at the same location, only the dentist whose name appears on the list is a Participating Dentist.

Selecting a Dentist

You are free to select the dentist or dental specialist of your choice. All family members are entitled to select their own dentist. You may utilize the services of a participating specialist whether or not you utilize the services of a participating general dentist for your routine care. You may change your dentist at any time for any reason. **It is important to understand that the Fund does not recommend or endorse any particular dentist.** You should exercise the same care and apply the same criteria in selecting a participating dentist as you would in selecting a non-participating dentist.

Scheduling an Appointment

After selecting a dentist from the directory, call the dental office for an appointment. Identify yourself as a member of the CALA Welfare Fund Metrodent Premier Dental Plan when scheduling your appointment and have a copy of this booklet with you at the time of your visit. **Due to the fact that there are occasional additions and deletions, when scheduling your appointment, PLEASE VERIFY THAT THE DENTIST IS STILL PARTICIPATING. If you have any questions, please contact Administrative Services Only, Inc. at 516.396.5500 or 1.800.537.1238.**

Filing a Claim

Participating dentists will handle all the necessary paper work. You simply complete the Assignment of Benefits section of your claim form and reimbursement will be paid directly to the dentist. You will be responsible for reimbursing the dentist only in those instances stated above. **Claims are administered by Administrative Services Only, Inc. at the address below.**

If you have any specific questions regarding the treatment you received or charges incurred, please call or write:

ADMINISTRATIVE SERVICES ONLY, INC.
303 Merrick Road, Suite 300
Lynbrook, NY 11563
516.396.5500 or 800.537.1238

FOR THE MOST CURRENT LISTING OF PARTICIPATING DENTISTS PLEASE VISIT OUR WEBSITE at **www.asonet.com**

Nota bene: Neither the Trustees nor the Welfare Fund employees or Administrator make any representation with respect to the competency of any dentist, optician, optometrist, or other service provider, nor will the Trustees or any of its employees be liable to any plan member or their dependents for any malpractice, error, omission, or carelessness by a dentist, optician, or other service provider obtained through the Plan, or an accident or other problem a covered individual may have with their premises. The forgoing is a condition of using the Plan for covered services. Individuals covered by the Plan are responsible for making their own determination of the advisability of using any panel dentist, optician, optometrist, or other service provider made available by the Fund.

SCHEDULE OF COVERED DENTAL EXPENSES

Reimbursement amounts effective for claims incurred on or after January 1, 2016. Dollar amounts listed are maximum amounts.

Examinations, Prophylaxes and X-rays		
0150, 0120, 00110, 0140	Examination and charting Max two in a calendar year	$30
210	Full mouth series	$87
220	Intra-periapical — first film	$14
230	Intra-periapical — each additional film	$11
240	Intra-oral film, occlusal view — each film (in lieu of standard x-rays, endentulous jaws)	$33
260	Extraoral — each additional film	$27
270	Bite-wing — single film	$10
272	Bite-wing — two films	$17
274	4 bite-wing series — One every six months	$46
277	Vertical bitewings — 7 to 8 films	$57
290	Anterior-posterior film — head and jaws	$114
291	Lateral film — head and jaws	$40
321	Temporomandibular joint film One per 12-month period	$57
330	Panoramic film (in lieu of standard x-rays)	$74
340	Cephalometric film	$85
350	Oral/facial photographic images	$37
460	Pulp vitality test	$25
470	Diagnostic casts	$75
477	Special stains not for microorganisms	$60
1110	Prophylaxis — adult Max 2 in a calendar year	$57
1120	Prophylaxis — child Max two in a calendar year	$57
1351	Pit + Fissure sealant to age 16 per tooth, per application Max two applications per tooth lifetime	$38

Fluoride Treatment		
1208	Patient must be 19 or younger One treatment per calendar year	$29

Extractions		
7140	Extraction erupted tooth or exposed root	$117
7210	Surgical removal of tooth (demonstrated by x-ray)	$195
7220	Tissue impactions (demonstrated by x-rays)	$244
7230	Partial bony impaction (demonstrated by x-rays)	$325
7240	Complete bony impaction (demonstrated by x-rays)	$381
7241	Removal of impacted tooth Completely bony with unusual surgical complications	$479
7290	Surgical repositioning of teeth	$378

Restorations		
Inlays, Onlays, Crowns and other prosthetic appliances are subject to five-year frequency limit. Please refer to Exclusions.		
2140	Silver amalgam — one surface primary/permanent	$98
2150	Silver amalgam — two surfaces primary/permanent	$126
2160	Silver amalgam — three surfaces primary/permanent	$152
2161	Silver amalgam — four+ surfaces primary/permanent	$186
2330	Resin-based composite — one surface anterior	$98
2331	Resin-based composite — two surfaces anterior	$124
2332	Resin-based composite — three surfaces anterior	$152
2335	Resin based composite — four or more surfaces or involving incisal angle (anterior)	$180
2391	Resin-based composite — one surface posterior	$114
2392	Resin-based composite — two surface posterior	$149
2393	Resin-based composite — three surface posterior	$186
2510	Inlay (metallic) — one surface	$551
2520	Inlay (metallic) — two surfaces	$325
2530	Inlay (metallic) — three or more surfaces Max, one tooth	$720
2542	Onlay (metallic) — two surfaces	$706
2543	Onlay (metallic) — three surfaces	$739
2544	Onlay (metallic) — four or more surfaces	$768
2610	Inlay (porcelain) — one surface	$551
2620	Inlay (porcelain) — two surfaces	$625

Restorations		
Inlays, Onlays, Crowns and other prosthetic appliances are subject to five-year frequency limit. Please refer to Exclusions.		
2630	Inlay (porcelain) — three or more surfaces Max, one tooth	$720
2710	Acrylic jacket	$329
2740	Porcelain jacket	$832
2750	Crown (porcelain) — fused to high noble metal	$820
2751	Crown (porcelain) Fused to predominately base metal	$764
2752	Crown (porcelain) — fused to noble metal	$785
2780	Crown — ¾ high noble metal	$787
2783	Crown — ¾ porcelain/ceramic	$809
2790	Crown — full high noble metal	$791
2910	Recement inlay onlay/part coverage restoration	$66
2920	Recement crown	$69
2930	Prefab stainless steel crown — primary tooth	$188
2931	Prefab stainless steel crown — permanent tooth	$223
2940	Sedative filling	$72
2950	Crown buildup, including pins	$179
2951	Pin retainer per tooth in addition to restoration	$38
2952	Cast post, & core in addition to crown	$297
2954	Prefab post & core in addition to crown	$257
2962	Labial veneer — laboratory	$672

Palliative		
9110	Emergency visit for pain relief (no other service provided)	$59
9310	Consultation	$124
9430	Office visit observation (no other service provided)	$68
9910	Application of desensitizing medicament	$36

Periodontics Confirmation of Periodontal Diagnosis Required)		
4210-4250	Surgical Periodontics (such as Gingivectomy Mucogingival surgery, each full quadrant	$446
4260	Osseous Surgery, each full quadrant	$631
4263	Bone replacement graft - first site in quad	$191
4264	Bone replacement graft - each additional	$100
4266	Guided Tissue Regeneration	$150
4270	Pedicle Soft Tissue Graft	$400
4277	Free Soft Tissue Graft	$400
4381	Localized Delivery of Chemo Agents-per tooth	$50
	Root scaling, curretage and minor bite correction (including prophylaxis) — each treatment Max 4 treatments in any 12 months	
4341	Periodontal root planing — per quadrant	$146
4342	Periodontal scaling & root planing — 3 teeth	$87
4355	Full mouth debrid enable comp evaluation	$97
4910	Periodontal maintenance procedure following active therapy	$87
9951	Occlusal adjustment — limited	$50
9952	Occlusal adjustment — complete	$100

Oral Surgery		
3410	Apicoectomy — anterior	$504
3421	Apicoectomy — bicuspid	$550
3425	Apicoectomy/periradicular surgery — molar	$622
3426	Apicoectomy/periradicular surgery	$257
3450	Root resection	$200
7260	Closure of oral antral fistula	$2,016
7250	Removal of residual roots	$150
7280	Surgical access of unerrupted tooth	$350
7282	Surgical exposure of impacted/unerrupted tooth (aid eruption)	$250
7285	Biopsy of oral tissue hard	$811
7286	Biopsy of oral tissue soft	$333
7310	Alveoloplasty with extractions	$227
7320	Alveolectomy with no extractions — per quad	$328

Oral Surgery		
7450	Removal of cysts, including necessary extractions up to 1.25 cm	$722
7451	Removal of cysts, including necessary extractions > to 1.25 cm	$1,134
7630	Upper or lower jaw, open reduction	$3,000
7640	Lower jaw, closed reduction	$2,721
7953	Bone graft replacement for ridge preservation	$400
7960	Removing labial frenum	$202

Root Canal Therapy (x-ray of satisfactory completion required) Removal of pulp and filling canal:		
3110	Pulp cap direct (excluding final restoration)	$44
3120	Pulp cap — indirect	$35
3220	Therapeutic pulpotomy	$104
3310	Anterior	$507
3320	Bicuspid	$642
3330	Molar	$777
3430	Retrograde filling — per root	$153
3310	Retreatment — anterior	$707
3320	Retreatment — bicuspid	$842
3330	Retreatment — molar	$977

Space Maintainers		
1510	Space maintainer — fixed unilateral	$273
1515	Space maintainer — fixed bilateral	$360
1525	Space maintainer — removable bilateral	$464

Bedside Call (home or hospital)		
9410	House/extended care facility call	$163
9420	Hospital call	$225

Repair of Prosthetic Appliances		
5281	Removable unilateral partial denture 1 piece cast metal	$556
5410, 5411, 5421, 5422	Denture adjustment	$35
5520	Replace missing/broken teeth — complete	$79
5610	Repair resin denture base	$103
5620	Repair cast framework	$111
5630	Repair or replace broken clasp	$134
5640	Replace broken teeth — per tooth	$87
5650	Add tooth to existing partial denture	$119
5710	Rebasing, one per denture per three-year period	$351
5730,5731	Reline complete — chairside One per denture per three-year period	$198
5740, 5741	Reline partial — chairside One per denture per three-year period	$125
5750, 5751	Reline complete — laboratory One per denture per three-year period	$225
5760, 5761	Reline partial— laboratory One per denture per three-year period	$175
2980	Crown repair — by report	$150

Prosthetic Services

The replacement of dentures, bridgework, or other prosthetic appliances is subject to a five-year frequency limit. Please refer to Exclusion.

Supplying, fitting and inserting appliances/dentures, full and partial		
5110	Complete denture — maxillary	$864
5120	Complete denture — mandibular	$864
5130, 5140	Complete immediate denture Permanent dentures inserted within 12 months from date of insertion of intermediate denture Max each jaw	$942
5211, 5212	Partial denture — resin base	$743
5213, 5214	Partial, bilateral, chrome cobalt alloy or gold base Two+ full clasps with occlusal rests, acrylic attachments, and porcelain or acrylic teeth, Each jaw	$954
5510	Repair broken complete denture base	$95
5520	Replace missing or broken teeth Complete denture — each tooth	$79
Bridgework Fixed		
6240	Pontic — porcelain fused to high noble metal	$694
6242	Pontic — porcelain fused to noble metal	$676
6250	Pontic — plastic processed to gold	$685
6252	Pontic resin with noble metal	$625
6545	Maryland bridge retainer	$450
6750	Porcelain fused to gold	$792
6752	Porcelain fused to noble metal	$756
6780	Three-quarter crown	$747
6790	Full cast high noble metal	$765
6791	Full cast basic metal	$725
6602	Inlay — cast high noble metal two surfaces	$619
6603	Inlay — cast high noble metal 3+ surfaces	$680

Orthodontics SUBJECT TO ANNUAL AND LIFETIME FREQUENCY LIMITATIONS		
8010, 8030, 8060, 8080, 8090	Diagnosis and initial orthodontic appliances	$608
8670	Periodic Orthodontic Treatment Per month of treatment for a max of 20 months	$124
8680	Retainer fabrication and placement	$200
8681	Passive orthodontic visit Per 6 months of treatment for a max of 18 months	$95

Other Procedures		
9215	Local anesthesia	$19
9223	Deep sedation/administration of general anesthesia Each 15 minutes to a max of 45 minutes	$118
9230	Analgesia anxiolysis inhalation of nitro	$41
9243	Intravenous moderate (conscious) Per 15 minutes to a max of 30 minutes	$93
9940	Occlusal guard — by report	$203

Implant Procedures Lifetime Max — Four Teeth		
When utilizing a Participating Provider, please confirm if he/she accepts this allowance as payment in full prior to commencing work		
6010	Surgical placement implant body: endosteal	$1,443
6056, 6057	Custom/prefabricated abutment with placement	$449
6059	Abutment supported porcelain fused to high noble metal	$820
6060	Abutment supported porcelain fused to base metal	$775
6065	Implant supported porcelain/ceramic crown	$818

Note: No benefits are payable for any Dental Expenses not listed in the foregoing Schedule of Covered Dental Expenses

VISION EXPENSE BENEFIT

If you incur charges for the purchase of eyeglasses or contact lenses while covered by the Fund, you will be reimbursed for an amount equal to the regular and customary charges incurred for such Vision Care Services but not more than $200 per person in a calendar year. **Part-time** employees for whom the State of New York contributes only half the annual full-time employee required contribution to this Fund are eligible for half the benefits of the benefits stated in this section.

You have the right to **opt out** of eligibility for vision benefits for yourself or your dependents if you so wish by notifying the Fund office.

Definitions

Charges for Vision Care Services means charges for:

1. Examinations performed by a licensed optometrist or ophthalmologist;
2. Lenses prescribed by such persons (including prescription sunglasses and contact lenses);
3. Frames purchased in conjunction with lenses newly prescribed by such persons.

Exclusions

No payments will be made for:

1. More than one examination in any calendar year except when the examination results in a different prescription for lenses;
2. Non-medically required lenses in excess of one pair per calendar year;
3. Non-medically required frames in excess of one set during any calendar year;
4. Non-prescription eyeglasses or sunglasses;
5. Medical or surgical treatment for disease entities of the eyes;
6. Expenses incurred for services performed or supplies furnished by anyone other than a licensed optometrist, ophthalmologist or optician.

When To File A Claim

You must file a vision care claim form as soon as you incur, or one of your insured dependents incurs, expenses for which the Vision Care Benefits plan

provides benefits, **but not later than 90 days from the date such expenses were incurred**.

Preferred Optical Provider — Comprehensive Professional Systems

You or your dependents may use any of the optometrists who are part of the Comprehensive Professional Systems network of providers. There are approximately 300 in the tri-state area. A list of Comprehensive Professional Systems optometrists is available from the CALA Welfare Fund Office or by visiting **www.cpsoptical.com.**

If you do so, you will be entitled to **either**

Eyeglasses and the following:

1. An eye examination, a frame with a retail value of up to $175, and single vision plastic lenses, including photosensitive lenses, including tint, ultraviolet coating, scratch resistant coating, and oversize lenses; or
2. The same as (a) but with FT 25/28/35 bifocal, executive bifocal, or invisible plastic bifocal lenses; or
3. The same as (a) but with trifocal plastic lenses; or
4. The same as (a) but with standard progressive multifocal lenses (including adapter, PE 11, VIP or comparable but NOT Varilux); or
5. The same as (a) but as prescription sunglasses.

OR

Contact lenses as follows:

1. Contact lens fitting (and follow-up visits) with either Bausch and Lomb or Amsoft clear daily wear contact lenses, extended wear contact lenses, or a six-month supply of select disposable contact lenses (Bausch & Lomb Softlens 38, Ciba Focus 1-2 week lenses, Acuvue, Acuvue 2, Biomedics 38, or Frequency 55). A credit of $175 will be applied toward the purchase of any contact lenses not included in the CALA program plus a 10% discount off of the fit and follow-up visit.

You or your dependent as the patient will be responsible for the following surcharges:

1. Varilux comfort progressive lenses. $150
2. “Transitions” single vision plastic lenses $85
3. “Transitions” bifocal plastic lenses $135

4. Polycarbonate lenses. $55
5. Super thin 1.60 single vision hi index lenses $60

A 30% discount will be given on all non-covered items, excluding frame overages, co-payments, and already discounted or credited services.

Nota bene: Neither the Trustees nor the Welfare Fund employees or administrator make any representation with respect to the competency of any dentist, optician, optometrist, or other service provider, nor will the Trustees or any of its employees be liable to any plan participant or their dependents for any malpractice, error, omission, or carelessness by a dentist, optician or other service provider obtained through the Plan or an accident or other problem a covered individual may have with their premises. The forgoing is a condition of using the Plan for covered services. Individuals covered by the Plan are responsible for making their own determination of the advisability of using any panel dentist, optician, optometrist, or other service provider made available by the Fund.

Lasik Eye Surgery

The Optical Benefit Program has been expanded to include coverage for Lasik Eye Surgery as follows:

- The Lasik Surgery must be performed on or after January 1, 2013
- This benefit is for participants and spouses only
- You will be reimbursed a maximum of $200 per calendar year **in lieu of any other optical benefit**
- You will be responsible for submitting the expense each year
- You may submit for reimbursement for up to five consecutive years

EXAMPLE: If you incur Lasik Eye Surgery, you may submit for reimbursement once every calendar year up to a maximum of five times in five consecutive years. Complete the Optical Claim Form, attach a copy of the provider invoice for the Lasik Eye Surgery, and submit it to Administrative Services Only, Inc. for reimbursement. The patient will not be able to submit for any other optical benefits during this five-year period.

EDUCATIONAL ASSISTANCE

You will only be reimbursed for the direct cost of the seminar or course to the maximum amount set each year by the Trustees. The seminar or course must be related to your Unified Court System bargaining unit job. The amount of the reimbursement will depend on the contributions received by the Fund and the number of claimants in each plan fiscal year. There will be no reimbursement for material, food, transportation, lodging, or other costs expended for anything other than the seminar or course and necessary reading materials.

Claims must be submitted within three months of the completion of course-work. For more information concerning this benefit, which is only available to employees of the Unified Court System who participate in this Fund, please contact the Union Office at 212.387.8707. Claim forms are available on NYSCALA website at www.nyscala.com or by calling the Fund office.

SICK LEAVE BANK

The Union has negotiated a sick leave bank that, in certain circumstances, provides additional paid sick leave from a sick leave pool if both your sick and annual leave credits are exhausted and you are medically unable to re-turn to work. Please contact the Union for further details if you find yourself in this situation.

SHORT-TERM DISABILITY

If you have exhausted all of your annual leave, sick leave, and sick leave bank entitlement, but remain medically unable to return to work, you may apply for the Union's short-term disability benefit. The Fund will provide a benefit not to exceed $1,000 per month for a maximum of six months. Claim forms are available at www.nyscala.com or via the Fund office.

SELF-PAY EXTENDED TERM DISABILITY

Although the Fund does not provide extended disability insurance, the Union has arranged to make extended term disability insurance available through Madison Planning Group to members who wish to purchase it themselves. If you wish to buy a policy, you may pay for it through payroll deduction. Plans are currently being offered through several different insurance compa-nies. Please contact Jon Schleuter at 877.377.4420. This is in addition to the Short-Term Disability that the Fund pays.

BASIC GROUP TERM LIFE INSURANCE

This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals, is contained in the Life Insurance Group Policy. The terms, conditions, limits, and exclusions shown in the Life Insurance Group Policy shall govern. Please visit **www.nyscala.com**

The Plan provides group term life insurance coverage for each full-time and part-time employee.

You may change your beneficiary at any time by contacting the Plan Administrator for a new Life Insurance Beneficiary Designation form. The change is effective only upon receipt of your fully completed life insurance beneficiary form.

If you die while insured for these benefits, the amount of your life benefits shown in the table below is payable to your beneficiary. Your beneficiary may choose to have this amount paid in a lump sum or in installments.

Schedule of Basic Life Insurance and Accidental Death And Dismemberment for Active Members

Active Members — full-time and part-time $50,000

Age Reduction of Basic Life Insurance . . . . . None

Accidental Death & Dismemberment (AD&D) $50,000

Life Insurance Beneficiary

The beneficiary of the individual's insurance for loss of life, including those with respect to accidental death, if any, will be the person(s) named by the insured as shown on the records kept by the Fund on this policy. The insured may change such beneficiary at any time by giving written notice to the Plan Administrator.

If the Insured has not named a beneficiary, or the named beneficiary is not surviving at the time of the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

1. The Insured's legal spouse;
2. The Insured's surviving child(ren) (including legally adopted child(ren), in equal shares;

3. The Insured's surviving parents, in equal shares;
4. The Insured's surviving siblings, in equal shares; or, if none of the above;
5. The Insured's estate.

Life Insurance Conversion

An individual or dependent may elect to buy an individual life insurance policy if his or her life insurance ends.

Proof of Life Insurance Claim

Written proof of claim must be given to the insurer through the Fund on the insurer's forms within 90 days after the date of loss for which claim is made. Late proof will be accepted only if it is shown to have been furnished as soon as is reasonably possible.

Accidental Death and Dismemberment Insurance (AD&D)

If an insured suffers any one of the losses listed below as a result on an injury, benefits will be paid as shown. The loss must be caused solely by an accident that occurs while the person is insured, be the result of an injury, directly and independently of all other causes, and must occur within 90 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Basic Life Insurance and Accidental Death and Dismemberment.

All benefits other than for loss of life will be paid to the member. Benefits for loss of life will be paid to the member's beneficiary. The amount in the Schedule of Life Insurance Benefits and Accidental Death and Dismemberment is paid for loss of:

1. Life
2. Both hands or both feet
3. Sight of both eyes
4. Speech and hearing
5. Any two or more:
    - One foot
    - One hand
    - Site in one eye

One-half the amount shown in the Schedule of Life Insurance and Accidental Death and Dismemberment Benefits is paid for loss of:

1. One hand; or
2. One foot; or
3. Sight in one eye

Loss of hand or foot means loss by cutting off at or above the wrist or ankle joint. Loss of sight means total loss that cannot be recovered. If a member has more than one loss due to one accident, payment will be made only for the loss with the largest benefit. Payment will be made only for the loss that results from the accident without regard to any former loss.

What Is Not Covered Under AD&D

Please refer to life insurance group policy for exclusions and limitations.

OPTIONAL LIFE INSURANCE

This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained in the Life Insurance Group Policy. The terms, conditions, limits, and exclusions shown in the Life Insurance Group Policy shall govern. **Please visit www.nyscala.com**

Active full-time or part-time employees (with more than 20 hours per work week) will have the option of purchasing **Optional Term Life Insurance. This benefit would be <u>in addition</u>** to the $50,000 Group Basic Term Life and Basic Accidental Death and Dismemberment Insurance Policy provided to you at no cost.

You will have the option to purchase additional individual insurance for yourself. When purchasing additional insurance for yourself, you also may purchase insurance for your spouse and/or dependent children. If you do not purchase additional insurance for yourself, you will not have the opportunity to purchase insurance for your spouse or dependent children. You may purchase coverage in increments of $25,000 to $500,000. Upon hiring, you can apply for up to $50,000 for member and $20,000 for spouse without providing evidence of insurability. All other purchases or increases will be subject to underwriting approval. All applicants must complete and return

the Evidence of Insurability form. If you have any additional questions regarding your Group Term Life Insurance or the Optional Life Insurance Benefit, **please contact Administrative Services Only, Inc. at 1.800.537.1238 ext. 9477.**

Spouse Optional Term Life Insurance Coverage

You may purchase coverage for your spouse in increments of $5,000 to $250,000, not to exceed 50% of your Optional Term Life coverage amount.

Children Optional Term Life Insurance Coverage

You may purchase coverage for your eligible dependent children in increments of $2,000 to $10,000, not to exceed 50% of your Optional Term Life coverage amount. There are no health requirements for this coverage, which begins from 14 days, and continues to age 19, if unmarried. If unmarried, dependent on you, and a full-time student, coverage continues to age 25.

Frequently Asked Questions

"When can I enroll for Optional Term Life Insurance coverage?"

You may choose to enroll at any time.

"When will coverage go into effect?"

For your coverage to become effective, you must be actively at work during the enrollment period and on the effective date of your coverage. If your dependents are confined for medical treatment at home or elsewhere, their coverage will begin when confinement ends. Refer to the Life Insurance Group Policy for details.

"Can I increase my coverage in the future?"

Yes, you can increase your coverage up to your plan's maximum coverage amount. However, evidence of good health satisfactory to First Reliance Standard Life Insurance Company will be required as previously noted.

"How can I enroll?"

To enroll, simply complete the Election/Rejection Form. Then, return it as instructed. You will receive correspondence confirming the amount of your coverage.

Conversion to Individual Insurance Coverage

Upon termination of employment, you may convert your coverage to an individual life Insurance policy without having to provide evidence of good health.

Waiver of Premium

Payment of your premium can be waived if you meet all these conditions:

1. You are less than 60 years old when your disability begins;
2. You are totally disabled and unable to work for at least nine continuous months; and
3. You continue to be totally disabled.

The Waiver of Premium Benefit Terminates at age 65. This provision may vary by state. If any of the conditions above apply **YOU MUST CONTACT THE FUND OFFICE IMMEDIATELY.**

Accelerated Benefit Option

If terminally ill, you can get a partial payment of your group term life insurance benefit. You can use this payment as you see fit. In the event of your death, your beneficiary will receive a benefit payout that has been reduced by the amount you receive. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

SUBROGATION

(Dental and Optical Benefits)

If this Fund makes payment to or for the benefit of a covered member or eligible dependent, it shall have the primary right to make and prosecute claims which such covered member or dependent may have against third parties and to reimburse itself for the full amount of benefits it paid out as a result of the complained of conduct of such third parties. Any excess recovered will be paid over to the covered member or dependent. In the event recovery is made against third parties by such covered employee or dependent, by suit or otherwise, the Fund shall be fully reimbursed and, to

that end, shall have a lien against such proceeds in such amount. Failure or refusal to cooperate with the Fund in making or prosecuting such claims or liens by the Fund or in making such payments to the Fund shall be sufficient reason for withholding payment of any Fund benefits.

AMENDMENT OR TERMINATION OF THE PLAN

The Trustees intend to continue the Plan described in this booklet indefinitely. Nevertheless, they reserve the right, pursuant to the provisions of the Agreement and Declaration of Trust of the Fund, to terminate or amend the Plan at any time, in any respect, with or without prior notice. The Plan may be terminated by the Trustees when, for example, there is no longer in effect an agreement between an Employer and the Association requiring payment to the Fund. Upon termination of the Plan, Trustees would apply the monies of the Fund to provide benefits or otherwise carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed. The Trustees have no present plans to terminate the Fund.

CLAIMS REVIEW PROCEDURE

Members who have received notice that their claim has been denied may request a review by the Board of Trustees of the denied claim within 60 days of the receipt of the notice of denial. Claimant or their authorized representative may request a review, may have the opportunity to review pertinent documents, and may submit issues and comments in writing. Requests for review must be made in writing and should be sent to the Fund Office.

The Board of Trustees will review your claim at its next regular scheduled meeting. However, if the request for a review is received less than 30 days before a scheduled meeting, the review may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, such as a need for more facts by the Board of Trustees, a decision may be made at the third meeting following the date the request for a review is made. The decision of the Board of Trustees will be in writing and will try to include the reason(s) for its decision and specific references to plan provisions on which the decision is based. When you request a review of a denied claim, you will be notified of the approximate date you can expect to receive a decision.

The Trustees reserve the right to make a final and binding interpretation of

this plan, including its application, which will not be made in an arbitrary and capricious manner.

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND PRIVACY NOTICE

Section 1: Purpose of This Notice and Effective Date

This Notice Describes How Health/Medical Information About You May Be Used And Disclosed And How You Can Get Access To That Information. Please Review It Carefully.

This Privacy Notice applies to the offices of the Citywide Association of Law Assistants of the Civil, Criminal and Family Courts in the City of New York Welfare Trust Fund (the "Fund"), the optical coverage, and dental coverage and services through other business associates of the Fund.

Effective date: The effective date of this notice is October 5, 2015.

This Notice is required by law: The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI);
2. Your rights to privacy with respect to your PHI;
3. The Fund's duties with respect to your PHI;
4. Your right to file a complaint with the Fund and/or with the Secretary of the United States Department of Health and Human Services (HHS); and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) means all individually identifiable health information related to an individual's past, present, or future physical or mental health condition, or to payment for health care services. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, or without giving you the opportunity to agree or object, in the following cases:

- At your request. If you request it, the Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it.
- When required by applicable law.
- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court¬-ordered discovery request.
- Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).

- Law enforcement emergency purposes. For certain law enforcement purposes, including:
    1. identifying or locating a suspect, fugitive, material witness or missing person, and
    2. disclosing information about an individual who is or is suspected to be a victim of a crime.
- Determining cause of death and organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
- Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent.
- Research. For research, subject to certain conditions.
- Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including to the target of the threat.
- Workers' compensation programs. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- For treatment, payment or health care operations. The Fund and its business associates will use PHI in order to carry out:
    1. Treatment,
    2. Payment, and
    3. Health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes, but is not limited, to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorizations).

For example, the Fund may tell a doctor whether you are eligible for coverage, or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician who reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes, but is not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Fund may use information about your claims to refer you (if appropriate) to a disease management program or to a healthy pregnancy program; or to project future benefit costs or audit the accuracy of our claims processing functions. The Fund does not use or disclose genetic information for any purpose, and it will not under any circumstances use or disclose genetic information for underwriting purposes.

Disclosure to the Fund's Trustees

The Fund also will disclose PHI to the Fund's Sponsor, which is the Board of Trustees of the Fund, for purposes related to treatment, payment, and health care operations. The Fund has amended its Plan Document to permit this use and disclosure, as required by federal law. For example, the Fund may disclose information to the Board of Trustees to allow them to decide an appeal.

In addition, the Fund may disclose "summary health information" to the Board of Trustees for obtaining premium bids or for modifying, amending or terminating the Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor such as the Board of Trustees has provided health benefits under a group health plan. Identifying information

will be deleted from summary health information, in accordance with federal privacy rules.

Except as otherwise indicated in this notice, uses and disclosures of your PHI will be made only with your written authorization, which is subject to your right to revoke your authorization.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Fund does not obtain psychotherapy notes, it must generally obtain your written authorization in order to use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Although the Fund does not sell PHI or use it for marketing purposes, it must obtain your written authorization before it may sell your PHI or use it for marketing purposes.

When You Can Object & Prevent the Fund from Using or Disclosing PHI

The Fund will disclose to your spouse/domestic partner the portion of your PHI that is directly relevant to your spouse's or domestic partner's involvement with your care or payment for that care, unless you notify the Fund's Privacy Official in writing (contact information below) that you object to our sharing that information with your spouse or domestic partner. In an emergency, or if you become incapacitated, the Fund may also disclose your PHI to other family members, relatives or close friends under certain circumstances as permitted by the Fund's procedures, unless you have previously notified the Fund's Privacy Official in writing that you do not want your information shared under those circumstances.

If you want the Fund to disclose your PHI routinely to persons other than your spouse or domestic partner, then you must complete an authorization form designating that person as authorized to receive your PHI. Any authorization you make can be revoked by you at any time. Authorization and revocation forms are available from the Privacy Official at the Fund Office.

Other Uses or Disclosures

The Fund may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. The form is available from the Fund's Privacy Official:

NYSCALA Welfare Trust Fund Privacy Official
303 Merrick Road, Suite 300
Lynbrook, NY 11563

You May Request Confidential Communications

The Fund will accommodate your reasonable request to receive communications of PHI confidentially by alternative means or solely at alternative locations (e.g., mailing information somewhere other than to your home address) where the request includes a statement that disclosure using the Fund's regular communications procedures could endanger you.

You or your personal representative will be required to complete a form to request confidential communications of your PHI. The form is available from the Fund's Privacy Official.

You May Inspect and Copy Your PHI

You have a right to inspect and to obtain a copy of your PHI contained in a "designated record set," defined below, for as long as the Fund maintains the PHI in a designated record set.

The Fund must provide the requested information within 30 days if the information is maintained on site at the Fund's offices, or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Fund is unable to meet the deadline.

You or your personal representative will be required to complete a form to request access to the PHI that the Fund maintains in a designated record set. The Fund may charge a reasonable fee to provide this information to you. Requests for access to PHI should be made to the Fund's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial setting forth the reason for the denial, a description of how you may exercise your review rights, and a description of how you may file a complaint with the Fund and/or HHS.

Designated Record Set means the enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for the Fund about you, or other information used in whole or in part by or for the Fund to make decisions about you. Information used by the Fund for quality control or peer review analyses, and not used to make decisions about you, is not part of a designated record set.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set that is maintained by or for the Fund for as long as the PHI is maintained in the designated record set, subject to certain exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if it is unable to meet the 60-day deadline. If the Fund denies your request in whole or part, the Fund must provide you with this denial in writing and explain in it the reason that your request is not being granted. You or your personal representative may then submit a written statement disagreeing with the denial. Your statement will be included with any future disclosure of the PHI at issue.

You should make your request to amend PHI to the Fund's Privacy Official. You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of Certain of the Fund's PHI Disclosures

At your request, the Fund also will provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within any 12-month period, the Fund will charge a reasonable, cost-based fee for each accounting the Fund provides after the first accounting.

Your Personal Representative

You may exercise your rights under this policy through a personal representative. Except as provided below in connection with parents of unemancipated minor children, or in certain emergency medical situations, your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor, unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family members, as described more fully at the beginning of Section 3 of this Notice. Certain other documentation may be used, including official legal documentation that demonstrates that under relevant state law, the representative is authorized to make health care decisions for you (e.g., appointment as a legal guardian, or a health care power of attorney).

Information that Does Not Identify You

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Section 4: The Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with a copy of this notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of this notice until such time as it may be amended. We are also required to notify you if your protected health information has been breached.

This notice is effective beginning on October 5, 2015. However, the Fund reserves the right to change its privacy practices and this notice, and to apply the changes to all the PHI that the Fund uses or maintains, including PHI that the Fund received prior to the date that it changed its privacy practices.

If a privacy practice is materially changed, a revised version of this notice will be posted prominently on the Fund's website within 60 days of the effective date of the material change, which may pertain to:

- The uses or disclosures of your PHI;
- Your individual rights;
- The duties of the Fund; or
- Other privacy practices stated in this notice.

A written copy of the most current version of this notice is available to you at any time upon request from the Fund's Privacy Official. Any other person, including dependents of named participants, also may obtain a copy of this notice at any time upon request from the Fund's Privacy Official.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI, or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to you;
- Disclosures made to the Secretary of the United States Department of Health and Human Services, pursuant to its enforcement activities under HIPAA;
- Uses or disclosures required by law; and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

Section 5: Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a written complaint with the Fund in care of the Fund's Privacy Official. The Fund will not retaliate against you for filing a complaint.

You may also file a complaint with:

Office for Civil Rights
U.S. Department of Health & Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312 New York, NY 10278

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, please contact the Privacy Official at the Fund Office.

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find the HIPAA rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the Fund's obligations under the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

NOTES

NYSCALA

Citywide Association of Law Assistants

Welfare Trust Fund

Citywide Association of Law Assistants

of The Civil, Criminal and Family Courts

in the City of New York

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