COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY, INC.

HEALTH AND WELFARE FUND

RETIREE BENEFIT SUMMARY PLAN DESCRIPTION

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

1 Old Country Road, Suite 282
Carle Place, NY 11514
(516) 794-0600
Fax (516) 794-7425
cobanc.org

January 2023

Dear Member:

We are proud to inform you of the benefits you are entitled to under our Retiree Benefit program provided by the Health and Welfare Fund. The Trustees have worked diligently to produce this comprehensive program.

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

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

In Unity,
Peter A. Piciulo Chairman

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General Information

Eligible Retirees

All retired members of the Court Officers Benevolent Association of Nassau County ("COBANC") as determined by the Office of Court Administration who are covered by the collective bargaining agreement by and between the State of New York and the Court Officers Benevolent Association of Nassau County are eligible for these benefits provided that they have retired from the Unified Court System and a contribution to the Fund is made on their behalf under a Collective Bargaining Agreement.

Eligible Dependents

Your eligible dependents under this Plan are:

1) Your lawful spouse (*unless legally separated*) **OR** your qualified domestic partner.

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

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

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

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

Stepchildren, legally adopted children, and children for whom you act as a legal guardian may be considered eligible dependents the same as your own

children, only if they depend on you for support and maintenance, and you provide documentary proof of your relationship to the Fund Office, e.g., birth certificate, marriage certificate, Domestic Partner Affidavit, or such other proof the Trustees may require. No child, other than one with whom you have one of the specified relationships designated above, may be considered an eligible dependent, regardless of whether the child lives with you or depends on you for support and maintenance.

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

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

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

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

Termination of Coverage

The described benefits for you and your eligible dependents will terminate if you cease to be an eligible Retiree, as determined by the Office of Court Administrators or the Plan is discontinued. A dependent's coverage will terminate when he or she is no longer an eligible dependent. Benefits will cease upon the death of the retired member (see COBRA extension).

Questions Concerning the Plan

Contact COBANC Health and Welfare Fund Office at 516-794-0600.

Schedule of Benefits
For Retired Members and Their Dependents:
Claims must be submitted within 12 months of the date of service or care provided.

For Retired Members

Life Insurance Benefit $3,000.00

For Retired Members and Their Dependents

Dental Expense Benefit
Maximum Amount (Annually Per Family). $4,050.00

Orthodontic Expense Benefit
This benefit is available to eligible members of any age, as well as their eligible dependents and spouse/domestic partner. For more information on Dependent Eligibility, see pages 4-6.
(Lifetime Maximum Per Person). $2,157.00

Vision Care Expense Benefit
Annual Maximum Amount. $180.00

Hearing Aid Benefit (every 4 years)
Maximum Amount. $500.00

Prescription Copayment Reimbursement Program
Maximum Benefit. .....$200.00 Per Family Annually
Claim form must be submitted by April 15th for payment of prior year's claim.

Dental Expense Benefit
Retired/Member and Dependent Coverage

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

Your Benefits

A network has been assembled of participating dentists who have agreed to provide services for COBANC members with minimal out-of-pocket cost for covered dental services.

To receive the advantages of In-Network benefits, visit the Administrator's website to locate a dentist who participates in your Dental Plan. When making an appointment, be sure to identify yourself as a retired member of COBANC's dental plan. You and your family members may go to any participating provider. Participating providers in the Capital PPO Network have agreed to provide services for COBANC members at reduced PPO fees. You need not go to the same dentist to receive In-Network benefits.

Effective January 1, 2024, COBANC members will have access to a national network of providers (United Healthcare PPO20 Network) when outside of the New York area. Copayments will apply and may vary based on the provider seen at time of care. To locate a participating provider within the UHCPPO20 Network, visit the Administrator's website at healthplex.com and key in your policy number 934413.

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

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

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

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

Predetermination of Benefits

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

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

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

Expenses That Are Not Covered

No benefits shall be payable for:

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

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

c) Which you are not required to pay.

d) Service performed solely for cosmetic reasons.

e) Replacement of lost or stolen appliance.

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

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

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

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

j) Orthodontia for any dependents over the age of 26, who did not start treatment prior to age 26.

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

l) Bridge attachments to implants when performed by an Out-of-Network provider.

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

Out of Network Schedule of Dental Procedures

Dental maximum is $4,050 per year per individual/per family.

	Maximum Payment
Preventive & Diagnostic	
Periodic Oral Examination*.	$14.00
Complete Series X-Rays**.	48.00
Panoramic X-Ray*.	36.00
Bitewing X-Rays* - 4 films.	14.00
Prophylaxis, Adult/Children*	22.00
Topical Application of Fluoride*	14.00
Sealants (Permanent Teeth only).	26.50
Space Maintainers - Unilateral.	86.00
Space Maintainers - Bilateral.	129.00
Emergency Exam.	20.00

* *Twice per calendar year*

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

Restorative	
Amalgam, one surface.	$21.00
Amalgam, two surfaces.	41.00
Amalgam, three surfaces.	62.00
Composite, one surface, Anterior	21.00
Composite, two surfaces, Anterior	41.00
Composite, three surfaces, Anterior	62.00
Gold or Porcelain Inlays (as substitutes for fillings)	
One or two surfaces.	36.00
Three or more surfaces.	58.00

Endodontics

Pulp Capping, maximum per tooth. $14.00
Pulpotomy 18.00
Root Canal Therapy, Anterior 214.00
Root Canal Therapy, Bicuspid. 320.00
Root Canal Therapy, Molar 428.00
Apicoectomy (Anterior). 114.00
Retrograde Filling. ..... 22.00 **Maximum Payment**

Oral Surgery

Routine Extractions. $36.00
Surgical Extractions (Sutures Included). 71.00
Impacted Teeth:
- Soft Tissue. 71.00
- Partial Bony 71.00
- Full Bony 129.00
- Alveolectomy, maximum per jaw 58.00

Periodontics

(These fees only apply when treatment is rendered by a board-certified specialist)

Scaling of Teeth, per quad. $73.00
Gingivectomy, per quad. 325.00
Perio Maintenance, per quad. 64.25

Prosthetics Fixed/Removable

Single Crowns

Porcelain Crown. $356.00
Porcelain with High Noble Metal Crown. 356.00
Acrylic with High Noble Metal Crown. 356.00
Stainless Steel Crown. 86.00
Cast Post. 45.00

Recement Crown..... 22.00

Bridgework

Porcelain with High Noble Metal Abutment. $356.00
Acrylic with High Noble Metal Abutment. 356.00
Porcelain with High Noble Metal Pontic. 285.00
Acrylic with High Noble Metal Pontic. 285.00
Recement Bridge. 22.00

Dentures

Complete Upper/Lower Denture. $428.00
Partial Upper/Lower Denture, Acrylic Base. 428.00
Partial Upper/Lower Denture, Cast Base. 428.00

Maximum Payment

Repairs/Relines

Replace Broken Tooth. $50.00
Repair Framework. 71.00
Add Tooth to Partial. 50.00
Replace Clasp 43.00
Reline Upper/Lower – Lab (once every three years). 129.00
Reline Upper/Lower – Office (once every three years). 93.00
Rebase Upper/Lower – (once every three years). 93.00

Implants/Crowns on Implants

Endosteal Implant*. $540.00
** Lifetime maximum of $3,240.00*

Implant Supported Prosthetics – Supporting Structure

Custom Fabricated Abutment..... 45.00

Single Crowns – Abutment Supported

Abutment Supported Porcelain/Ceramic Crown. 369.45

Single Crowns – Implant Supported

Implant Supported Porcelain Fused to High Noble Metal Crown. 356.00

Orthodontics (Study Models/Photos required prior to start of treatment. These fees only apply when treatment is rendered by a board-certified specialist)

This benefit is available to eligible members of any age or dependent children who are **under** age 26 when treatment begins.

Diagnosis and Initial Orthodontic Appliance for traditional braces. $447.00

Active Treatment per month of treatment. 84.00
Maximum 24 months. 2,016.00

Total Lifetime Maximum per Person. 2,157.00

Out of Network Vision Care Benefit Member and Dependent Coverage

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

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

Contact the fund office regarding In-Network benefits. You can also visit the fund website at cobanc.org and refer to member benefits.

Exclusions

Vision Care Expenses benefits are not payable for:

1. More than one eye examination in a calendar year.

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

(Note: This benefit is either one pair of glasses per calendar year or one pair of contact lenses per calendar year).

4. Sunglasses, unless used to correct vision.

5. Replacement of lost, stolen, or broken lenses or frames furnished under this benefit.

6. Eye examinations are required (1) as a condition of employment, which the employer is required to provide by a labor agreement, or (2) by a governmental body.

7. Special procedures such as orthoptics and visual training or medical or surgical treatment of the eye.

8. Services or supplies received because of an accident related to employment or disease covered under a Workers' Compensation Law or similar laws. Services or supplies (a) furnished by or for the U.S. Government; or (b) furnished by or for any other government unless payment is legally required; or (c) to the extent provided under any governmental program or law under which the individual is or could be covered. Anything not necessary for vision care; charges more than those usually made when there is no coverage or in excess of the general level in the area.

Hearing Aid Benefit
Retired Member and Dependent Coverage

This Plan will pay up to $500 for the purchase of a pair of hearing aids. (an individual hearing aid will be reimbursed up to $250) once every four (4) years. You must submit a claim form and attach receipts indicating the cost of the hearing aid. This benefit will be coordinated with any other medical insurance/coverage, which covers you or your eligible dependents. In no event will the member be reimbursed for more than the cost of the device. This benefit is not assignable to any third party.

Prescription Copayment Reimbursement Program
Member and Dependent Coverage

This benefit allows for reimbursement of any copayments, unreimbursed medical/dental expenses, prescription medications, office visits for you and your family, and medical insurance premiums deducted from the member or spouse's paycheck. Submit proof of payment along with a completed claim form to the claims department's address as stated on the form. The claim form must be submitted by April 15th for payments of the prior calendar year's claims.

Coordination of Other Plans

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

This coordination will apply in the event an expense is incurred for a covered event under this Health and Welfare Fund Plan, which also is covered under the other plan. Such determination to be made between the insurance companies.

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

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

This continuation will terminate on the earliest of:

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

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

c. the date This Plan is canceled.

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

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

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

Claim Processing

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

Make certain that all required information is completed on the claim form. The completed claim forms and necessary documentation (i.e., death certificates, proof of payment) should be returned to the Fund Office for eligibility certification and benefit processing. Dental and vision claim payments will be made directly to you, the member, unless you have assigned the payment to the provider of services.

Claim Appeals

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

information is necessary (if applicable); and appropriate information as to the steps to be taken if you wish to appeal the denial of your claim.

A review of this benefit determination may be requested by you or your authorized representative by submitting your appeal to us in writing at the following address: **Attention: Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569.** The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review. Your written request for review should include: • The member's name, identification number, and group policy number • The actual service for which a no-benefit coverage decision was made • The reasons why you feel benefit coverage should be provided • Any available medical information to support your reasons for reversing the benefit decision, if applicable If this claim was denied, in whole or part, you have the right to a detailed explanation for the basis of such denial, free of charge. An expedited appeal may be available to you if the patient's medical condition is such that the time needed to complete a standard appeal could seriously jeopardize the patient's life, health, or ability to regain maximum function. If we confirm that an expedited appeal is needed, we will complete the review within 72 hours of receiving the appeal request and any additional information. To arrange an expedited appeal, please call (800) 445-9090.

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

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

The Trustees' decision, with respect to your appeal, will be made promptly, and will not ordinarily be made more than ninety (90) days after the Plan receives your written appeal. If circumstances require an extension of time

for processing, a decision shall be rendered as soon as possible, but no later than 120 days after your appeal is received. If such an extension of time for review is required because of circumstances, written notice of the extension will be furnished to you (or your representative) prior to the beginning of the extension. The Trustees' decision on review will be in writing and will include specific reasons for their decision, written in a manner calculated to be understood by you, as well as specific references to the Pertinent Plan provisions on which their decision is based.

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

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

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

Legal Proceedings

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

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

Overpayment of Claims

If, at any time, you received an overpayment of any claim, you are required to return overpayment.