# Health Benefits Program

CSA

RETIREE WELFARE FUND

BENEFIT BOOK RETIREE MEMBERS JAN.1, 2022 EDITION


# RETIREE WELFARE FUND

40 Rector St., 12th Fl., New York, NY 10006
(212) 962-6061 | WWW.CSAWF.ORG

# Contents

# Message From the Chairperson of the Board of Trustees

Dear Colleague:

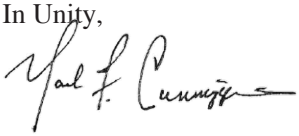
Our years in retirement should be free of concern in regard to the cost of necessary health care. The Trustees of the CSA Welfare Fund are determined to provide members of our Retiree Chapter with the most comprehensive benefit program possible.

To that end, the program described in this booklet has been designed to broaden and enhance your City-provided health benefit program. Additional benefits include coverage for dental, optical and hearing aid services, extended medical care and catastrophic coverage. The Fund also provides legal services benefits through an outside law firm which includes living wills, health care proxies, power of attorney documents and more.

We take great pride in the fact that this multi-faceted benefit program contains such a broad application of coverage to members. The Fund is also proud of its reputation for dedicated, prompt, and courteous service to its members.

On behalf of the staff and Trustees of the CSA Welfare Fund, I assure you that we stand ready to serve and assist you, should you need our help.

In Unity,



Mark Cannizzaro
Chairperson
Board of Trustees

# Forward

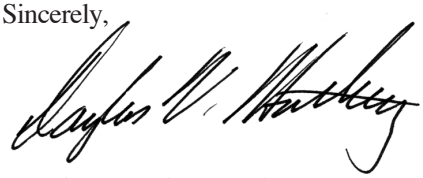
The Trustees of the CSA Retiree Welfare Fund are proud of the benefit program that has been developed over the years to provide our members with comprehensive protection from rising health costs. The program is unique in that it has been designed to provide members with choices. Members may choose a dental plan from a selection of four different plans, choosing between plans with little or no out-of-pocket costs or one which allows access to any dentist the member chooses to use. Optical services and hearing aid services are available either from a list of participating providers or through providers of the member's own choosing.

The Fund's benefit program is also unique in that it provides benefits not provided by other union health funds such as continued protection for surviving dependents of members who die. The Fund also has implemented a supplemental medical program to provide coverage for those services not fully covered by the City provided health plan or those excluded from the City provided health plan. In addition, a supplemental Major Medical benefit has been provided to assist members who incur medical and surgical costs not fully reimbursed by the member's primary medical plan, and a catastrophic medical (stop-loss) program to limit a member's financial risk to a reasonable level.

The continued success of the Fund depends upon two major ingredients, efficiency of operation and the cooperation of members. Members can help by including their social security number on all correspondence, notifying the Fund promptly of address changes, submitting changes in family status promptly, attaching original itemized paid receipted bills to all claims, auditing carefully the charges submitted by medical and dental practitioners before authorizing assignment of benefits to the practitioner, by using participating providers where possible and by submitting claims in a timely fashion.

The staff of the CSA Retiree Welfare Fund and I are dedicated to providing you with the best possible support and assistance with your health-related questions and issues so you are able to devote your time and energies to your retirement. We are proud of our history of providing the best possible support to our members and their dependents and assure you that we remain committed to providing this level of support in the years to come.

Sincerely,



Douglas V. Hathaway, Ph.D.
Administrator

# General Information

## Eligibility

You are eligible to receive benefits under the CSA Retiree Welfare Fund Program if:

- you are a Supervisory or Administrative employee who was separated from service with the Department of Education subsequent to June 30, 1970; and
- were covered by the CSA Welfare Fund at the time of such separation: and
- you are eligible for coverage by the City of New York to receive benefits; and
- are entitled to benefits paid for by the City through such program and
- the City makes a contribution to the Fund to provide you with Welfare Fund benefits.

Your coverage is paid for by the City of New York on the basis of the terms of a contractual agreement between the CSA, the Department of Education and the City of New York. Your coverage remains in effect so long as contributions are made by the City on your behalf.

## Dependents

Coverage for Dependents is a member benefit and is provided at the request of the member. Eligible dependents of covered members are fully covered for all CSA Retiree Welfare Fund benefits. Dependents, as defined by the Fund, are: the legally married spouse (or registered domestic partner) eligible for coverage by the City-provided health benefit plan; dependent children who are under the age of 26, any unmarried child, regardless of age, who is incapable of self-sustaining employment by reason of an extreme mental illness expected to be permanent, mental retardation, or a physical handicap and who became incapable prior to attainment of age 26 and is wholly dependent on the covered employee for support. Applications for such disabled status must be made prior to the age of 26 or at the time of enrollment.

Where a claim is made by, or on behalf of, a person over 26 years of age who is eligible as a handicapped child, proof of disability must be submitted to the Fund showing that the person is incapable of self-sustaining employment. This determination shall be made at the sole discretion of the Fund which may require that the individual submit proof of physical, psychiatric or other examination or evaluation.

Eligibility as a handicapped child is also dependent upon the child's eligibility for coverage by the New York City health insurance program. If the dependent child has been terminated for coverage under the New York City program, the Fund's coverage shall also be terminated.

A dependent child is defined as a natural child of the member, any legally adopted child, any stepchild who resides in your household, or any child supported by you or your spouse who permanently resides in your household and for whom you are legally responsible.

## Young Adult Age 26 Coverage

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) requires that young adults not yet age 26 are eligible for continued coverage by the CSA Retiree Welfare Fund. To enable these young adults to be covered under their parent's plan, the member should contact the Fund to request the registration information.

## Domestic Partners

Members who wish to apply for coverage for a domestic partner can obtain details concerning eligibility, enrollment, and tax consequences from the Office of Labor Relations, Domestic Partnership Liaison Unit at (212) 513-0470. Members who have registered a domestic partner for coverage by the City health plan and who are receiving such coverage will also be eligible for Welfare Fund Benefits for their domestic partner. Registration with the Domestic Partner Registry should be forwarded to the Fund when applying for Fund coverage.

# Enrollment

All new members must complete a CSA Retiree Welfare Fund Enrollment Card. Any changes in the member's family status such as marriage, divorce, separation, death of a dependent, the addition of a new dependent or change in designation of beneficiary require that the member request and complete a new enrollment card.

The Fund reserves the right to request documentation verifying the bona fide relationship of any dependent to the member (e.g. a birth certificate, marriage license, domestic partner registration, etc.) The Fund also reserves the right to deny or suspend benefits to members and/or their dependents when appropriate documentation of eligibility of the member or dependents is not provided to the Fund in a timely fashion and/or when requests for such documentation, or refund of monies paid by the Fund for ineligible dependents, is not provided to the Fund in a timely fashion.

# Termination of Dependent Coverage

Coverage with respect to a dependent will terminate upon the earliest to occur of the following dates:

- The date on which your personal coverage terminates
- The date on which the dependent fails to meet the criteria as a dependent under the plan
- The date the member requests that a dependent's coverage be terminated

# Continuation of Coverage

The Federal Government has enacted the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) which allows members and their eligible dependents the option of continuing their coverage for certain benefits provided by the City health plan and their Welfare Fund should their coverage be terminated. Under this law, the City health plan and the Fund will make available to the member, and/or his/her eligible dependents an opportunity to purchase most of the benefits at the group cost plus an administration charge not to exceed 2% of such cost.

Your dependents are permitted to purchase their coverage for a period of up to 36 months on the following conditions:

a) Spouse and children upon the death of the covered member.*
b) The spouse upon divorce or legal separation from the member.
c) The spouse and children of Medicare eligible members should the member cease to participate in the Fund's benefit program
d) Dependent children when they cease to be dependent children as defined in the Plan.

Coverage by the Fund cannot be continued beyond any of the following dates:

a) The date on which the Fund terminates its benefit program,
b) The date the premium is not paid by the individual.
c) When the individual becomes covered under any other health plan (if that plan does not include any pre-existing limitations or exclusions) or is eligible for Medicare benefits.
d) In the case of a spouse, when the spouse remarries and becomes covered under another group health plan. Federal COBRA rules do not apply for Medicare eligible members. However, as a result of a collective bargaining agreement the City and the unions have agreed to provide COBRA coverage to Medicare eligible members and their dependents.

Members are advised that if they wish to have continued coverage for themselves or any of their eligible dependents, they must notify the City Office of Labor Relations Employee Benefits Program, 22 Cortlandt St., 12th Floor, New York, NY 10007, as well as the Fund, within 30 days, should any of the following circumstances occur.

a) The member's coverage is terminated and no further contributions for coverage will be provided to the Fund by the City.
b) The member and spouse become legally separated or divorced.
c) A dependent child has reached his/her 26th birthday, is

CONTINUED ON NEXT PAGE

## Continuation of Coverage CONTINUED

not married, unemployed or employed without benefits from employer The City Office of Labor Relations, Employee Benefits Program, will provide the member with a COBRA application, or in the case of an eligible dependent child over the age of 26, a Young Adult Age 29 application and explanatory material.

Upon notification to the Fund, by the member or the City, the Fund will send an application for continued coverage to the member and/or the eligible dependent. The application will indicate the benefits to be provided, the cost for the coverage and the manner in which payments are to be made to the Fund.

Your opportunity to continue to obtain benefits from the Fund under this optional paid program will be available to you for no more than 60 days from the time you receive the application for coverage. If the application is not filed within that period of time the Fund may not be able to offer such optional paid coverage.

* See "Survivor Benefits" section.

## Young Adult Age 29 Coverage

In compliance with New York State legislation, beginning October 1, 2010, young adults through age 29 may elect to obtain coverage from the appropriate Fund. Participants electing this coverage will be billed the Fund's actual cost for providing benefits, as determined by its actuary, on a monthly basis. Failure to pay the monthly premium amount is grounds for immediate termination.

Young adults are eligible for this coverage if:

- They are unmarried
- Are age 29 or younger
- Live, work or reside in New York State or the Fund's coverage area
- Are not covered by Medicare
- Are not eligible for coverage through an employer

## Information and Claim Forms

Information and literature concerning the coverage provided by the Fund, and claim forms for benefits, can be obtained by visiting the Fund's website, www.csawf.org, calling or writing the Fund. When writing to the Fund, members should provide the last four digits of their social security number (as well as name and address). Claim forms for use under the GHI or other City basic health plans are obtainable directly from the insurance carrier, not from the Welfare Fund.

## Filing of Claims

Claims for all benefits provided by the Fund must be filed with the Fund no later than 12 months from the date services were rendered. Where the Coordination of Benefits provision is applicable, and the CSA Retiree Welfare Fund is the secondary plan, claims must be submitted within 12 months from the date payment was made under the primary plan. Claims that are not filed in accordance with the above time limitations will not be accepted.

## Non-Duplication Of Benefits

The purpose of the basic City health insurance program, as well as the CSA Retiree Welfare Fund, is to provide the broadest coverage possible to members to enable them to meet their health and welfare needs. In line with this objective, the City health insurance program and the Fund have a non-duplication of benefits rule. Under this rule an employee cannot be covered both as an employee and as a dependent at the same time.

Therefore, if your spouse also works for or is retired from the Department of Education (or another City agency participating in the New York City health insurance program), you may either (1) each enroll separately, or (2) enroll one as the dependent of the other. If you enroll separately, you may each select a different plan, but one may not cover the other as a dependent and all children must be enrolled with the same parent.

Furthermore, if you enroll separately, coverage by the Fund for supplemental benefits to the City provided plan for dependents with separate coverage may be based on the supplemental coverage available to the member as determined by the member's City health plan.

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# Coordination of Benefits (COB)

### *A. GENERAL*

You may be covered by two or more group health benefit plans, which may provide similar benefits. Should you have services covered by more than one plan, this Fund will coordinate benefit payments with the other plan. One plan will pay its full benefit as a primary insurer, and the other plan will pay secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a reasonable and customary charge. The Fund's program follows certain rules which have been established to determine which plan is primary; these rules apply whether or not you make a claim under both plans.

### *B. RULES OF COORDINATION*

The rules for determining primary and secondary benefits are as follows:

1. The plan covering you as an employee is primary before a plan covering you as a dependent.

2. When two plans cover the same child as a dependent, the child's coverage will be as follows: The plan of the parent whose birthday falls earlier in the year provides primary coverage. If both parents have the same birthday, the plan which has been in effect the longest is primary. If the other plan has a gender rule, (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See C below for special rules concerning dependents of separated or divorced parents.)

3. A laid-off or retired employee, or as a dependent of such a person, is secondary, and the plan covering you as an active employee, or as a dependent of such a person, is primary, as long as the other plan has a COB provision similar to this one.

### *C. SPECIAL RULES FOR DEPENDENTS OF SEPARATED OR DIVORCED PARENTS*

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan of the parent who has custody of the child is primary.

2. If the parent with custody of a dependent child remarries, that parent's plan is primary. The stepparent's plan is secondary and the plan covering the parent without custody is tertiary (third).

3. If the specific decree of the court states one parent is responsible for the health care of the child, then the benefits of that parent's plan are determined first. You must provide the Fund with a copy of the portion of the court order showing responsibility for health care expenses of the child.

### *D. EFFECT OF PRIMARY AND SECONDARY BENEFITS*

1. Benefits under a plan that is primary are calculated as though other coverage does not exist.

2. Benefits under a plan that is secondary will be reduced so that the combined payment or benefit from all plans are not more than the actual charges for the covered service. The plan that is secondary will never pay more than its full benefits.

If you and your spouse are both members of the CSA Retiree Welfare Fund, you can either be covered as a retired employee, or as a dependent but not as both. The Fund will pay benefits only once and will not coordinate with itself.

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### *NOTE*

Whenever payments have been made by the CSA Retiree Welfare Fund which are in excess of the maximum amount of payment necessary to satisfy a claim under the Coordination of Benefits Provision, the Fund shall have the right to recover such excess payments which were made to a member or eligible dependents.

## No-Fault Insurance

The Fund will not provide benefits for any services for which benefits are available under a No-Fault Automobile Policy.

## General Limitations and Exclusions Welfare Fund Benefits

Coverage under the CSA Retiree Welfare Fund will not apply to: an injury arising out of, or in the course of, any employment for wage or profit or a sickness for which benefits are provided under any worker's compensation or similar law; expenses incurred in a hospital owned or operated by any national government or any agency thereof; expenses incurred to the extent that payment is prohibited by any law of the jurisdiction in which the individual resides at the time the expenses are incurred; charges for which the individual is not legally required to pay or for charges which would not have been made if no insurance coverage had existed; such as services provided by a spouse, or by a parent to a child; charges in excess of the amount normally charged or considered by the Fund to be reasonable and customary; custodial care, education or training; injury or sickness arising out of war, declared or undeclared, or any act or hazard of war; charges for unnecessary treatment; charges for purely cosmetic surgery or treatment; expenses incurred which are in excess of the maximum annual or lifetime dollar limits established; for treatments which exceed the limit in the number of treatments established for that service; charges for services considered to be experimental or not generally accepted as an approved procedure or treatment program by the medical, governmental, or insurance community.

# Dental Benefit

***The CSA Retiree Welfare Fund offers to each member and his or her eligible dependents a choice of one of four different dental plans. There is a separate brochure (available upon request) for each of the plans that should be read carefully in order for you to understand the difference between the plans and your options, so that you can make an intelligent selection of the dental plan that best meets your needs. The following is a summary of these four plans.***

## The SIDS Dental Program—Option 1

Indemnity Plan Administered by Self Insured Dental Services

a) Use any dentist of your own choosing anywhere in the world.

b) You are provided with a listing of dentists who have consented to be participating providers. As participating providers, they have agreed to accept the reimbursement listed in the "Schedule of Allowances" as payment in full, subject to any co-payments or maximum allowances listed in the "Schedule".

c) If you choose to go to a non-participating dentist, you are reimbursed on the basis of a Schedule of Allowances that is described in a separate brochure. Your reimbursement is, of course, subject to the limitations in the schedule and maximum allowances.

d) The cost incurred for implants and related services will be reimbursed up to a maximum of $3,000 in a 36 month period as defined in the Schedule of Allowances and as shown below.

***REIMBURSEMENT FOR IMPLANTS AND IMPLANT-RELATED SERVICES SIDS Dental Plan***

| ADA Code | Description | Plan Pays | CSA Participating Provider Maximum Fee | CSA Retiree Co-Payment |
|---|---|---|---|---|
| 06010 | Endosteal Implant | $600.00 | $1,200.00 | $600.00 |
| 06040 | Subperiosteal Implant | $600.00 | $1,200.00 | $600.00 |
| 06050 | Transosseous Implant | $600.00 | $1,200.00 | $600.00 |
| 06056 | Prefabricated Abutment | $237.50 | $475.00 | $237.50 |
| 06057 | Custom Abutment | $237.50 | $475.00 | $237.50 |
| 06058 | Abutment Supported Porcelain Ceramic Crown | $337.50 | $675.00 | $337.50 |
| 06059 | Abutment Porcelain / Metal Crown | $337.50 | $675.00 | $337.50 |
| 06061 | Abutment Supported Crown | $300.00 | $600.00 | $300.00 |
| 06062 | Abutment Supported Cast High Noble Metal Crown | $337.50 | $675.00 | $337.50 |
| 06064 | Abutment Supported Cast Noble Metal Crown | $300.00 | $600.00 | $300.00 |
| 06065 | Implant Supported Porcelain Ceramic Crown | $487.50 | $975.00 | $487.50 |
| 06066 | Implant Supported Porcelain/High Noble Metal Crown | $487.50 | $975.00 | $487.50 |
| 06067 | Implant Supported High Noble Metal Crown | $487.50 | $975.00 | $487.50 |

The SIDS dental program now includes discount dental services provided through the Metrodent and Careington dental networks. Access to these expanded networks is provided at no cost to the participants. When performing a provider search at www.asonet.com, the Metrodent providers will be listed in green and the Careington dentists will be listed in red. The discounted charges are also listed at this location. When scheduling an appointment with a Metrodent or Careington dentists please inform the provider you are covered by ASO ( Administrative Services Only). ASO is SIDS parent company and is the contracting entity with these providers.

# Healthplex Dental Plan for New York - New Jersey

***Option II Enrollment in a pre-paid dental plan, Dentcare Dental plan by Healthplex. For members residing, either full or part-time, in the New York City - New Jersey Metropolitan area***

a) This plan is a pre-paid dental plan similar in concept to an HMO. Your Fund pays for the cost of this plan.

b) A member who selects this plan, upon enrollment in the plan, must select a primary care dentist from an extensive listing of participating Dentcare dentists. You may not use any other dentist unless referred by your Dentcare dentist. Members who enroll in this dental plan may change primary care dentist during each annual open enrollment period or at any time if they are dissatisfied with their dentist

c) The participating Dentcare Dentist will provide a member and the member's eligible dependents with total dental care at no charge to the patient other than a small charge for two or three services listed in the descriptive materials relating to crowns and orthodontics

d) Under this plan, there are no claim forms to be filed since the services are provided without a fee. The dentist is paid by the Fund each month, whether or not he/she has treated the patient. In effect, the dentist is on a retainer for the services

e) Specialized dental care, such as endodontics, oral surgery, and periodontics, if needed, is provided by specialists to whom your primary care dentist refers you

f) This plan has no dollar maximums and there are few restrictions in terms of limitations and services

g) Should you require emergency dental care while out of your geographic covered area, the cost for such care may be submitted to Healthplex for possible reimbursement

# Healthplex S200 – Florida

***Option III A Pre-paid dental plan, Healthplex S200 Dental Plan of Florida, sponsored by Healthplex for members who reside, part-time or full-time, in Florida.***

a) This plan allows the participant to select any dental provider from the list of participating providers. A copayment is required for many services. While you may use any provider, the provider must be a participating provider in this dental plan. Treatment by a non-participating dentist is limited to the elimination of pain.

b) A member who selects this plan, upon enrollment in the plan, is eligible to receive benefits immediately upon the effective date of enrollment of coverage with: no waiting period, no deductibles, and no claim forms to submit. Members have access to participating providers by calling customer service at 1-877-760-2247 and may go to any participating dentist without referral.

c) Under this plan, because of Florida regulations, the dentist must charge a fee for some of the services listed in the Schedule of Benefits while other services are provided without charge.

# Delta Dental - Deltacare USA Plan 2a

***Option IV A prepaid dental plan, sponsored by Delta Dental***

This dental plan provided by Delta Dental provides cost free dental care for preventive services such as cleaning, x-rays and exams. Basic restorative services such as fillings are either free or at substantially reduced fees. Major restorative services such as crowns, bridgework, and orthodontic care will cost the member 50% or less than the usual and customary charge for these services.

The Deltacare dental plan is a most appropriate choice for members who reside in a geographic area in which there are few or no SIDS participating dentists or Healthplex dentists. The panel of participating dentists is very broad covering the states of Florida, Arizona, California, New Jersey, Georgia, and Virginia. A listing of dentists in your geographic area is available upon request.

Members who enroll in Delta Dental plan may change primary care dentists during each annual open enrollment period or at any time if they are dissatisfied with their dentist.

## Summary

You may enroll in any one of the four plans listed prior.

If you do not submit an application for enrollment in either of the Healthplex plans, (Dentcare for retirees living in New York, New Jersey or The Healthplex America S200 Dental Plan for members living in Florida), or the Deltacare USA Plan 2A, you will automatically be covered by the SIDS plan.

You will have an opportunity to change your dental plan during the annual open enrollment period each October through December for coverage effective January 1st of the next calendar year. Members will not be locked into any dental plan for more than the year in which they are enrolled. Members who make no changes each October will remain in the plan previously selected.

# Optical Benefits

***All members and their eligible dependents are covered for optical benefits. The benefit, a maximum reimbursement of $100, is provided once every 12 calendar months.***

***Your reimbursement is as follows:***

| | |
|---|---|
| Single vision lenses and frame | $100.00 |
| Bifocal and multifocal lenses and frame | $100.00 |
| Single vision lenses only | $45.00 |
| Bifocal or multifocal lenses only | $45.00 |
| Frame only | $35.00 |
| Contact lenses including all services | $100.00 |

***EXAMINATIONS ARE ONLY COVERED AS PART OF A CONTACT LENS PACKAGE***

## How to Obtain Benefits

Write, call the Fund office, or submit a request through the CSA Welfare Fund website (www.csawf.org ) voucher request function. Click on the link, supply the requested information, and indicate the desired voucher. Please use the NOTES section to indicate which family members are to be issued a voucher. If a voucher expires and is unused it must be returned to the Fund and a replacement will be issued.

The voucher is to be signed by the patient and member and returned to the Fund with a copy of the itemized receipt for services purchased.

*Unsigned vouchers will be returned for signature, delaying reimbursement*.

# Visual Aid Machine Benefit

The Fund will include as a covered expense reimbursement of up to $500 towards the cost of a visual aid machine to assist members with severe visual loss. This benefit will be provided to members with severe vision impairment attested to by an ophthalmologist justifying the necessity for the device.

In order to apply for this once in a lifetime benefit, the member must submit an itemized bill for the device purchased, printed description of the device and a letter from a physician justifying the need for the device based upon the member's visual deficiency.

# Laser Eye Surgery Benefit

The Fund will include as a covered expense once in a lifetime benefit of up to $500 towards the cost of laser vision correction surgery. The Fund maintains a list of participating providers who have agreed to reduce their fees for CSA Retiree Welfare Fund members and will accept payment of the benefit directly from the Fund. Members can choose to have their laser eye corrective surgery at a non-participating provider with a $500 reimbursement directly to the member.

***HOW TO OBTAIN BENEFITS***

Write or call the Fund office requesting a laser surgery benefit claim form. For direct reimbursement to members using non-participating providers, portions of the claim form must be completed by the member and the surgeon. The completed claim form should be returned to the Fund office for processing and payment. The claim form must be accompanied by a proof of payment such as an itemized paid, receipted bill for the services provided.

# Multi-Focal Lenses

Effective January 1, 2008, the CSA Retire Welfare Fund provides supplemental reimbursement of up to $500 per eye for multi-focal lenses inserted after cataract surgery.

To obtain benefits, the member must submit an itemized paid bill to the Fund along with the Medicare explanation of benefits (EOB) when applicable.

# Hearing Aid Benefits

***All members and their eligible dependents, including children under the age of 26, are covered for hearing aid benefits.***

## Benefits

When using a participating provider, a benefit of up to $800, with a $35 co-payment made by the member to the participating provider, is provided for the purchase of one hearing aid every three years.

When choosing to use a non-participating hearing aid center, a direct reimbursement of up to $800 is made to the member.

## How to Obtain Benefits

Write, call the Fund office, or submit a request through the CSA Welfare Fund website (www.csawf.org ) voucher request function. Click on the clink, supply the requested information, and indicate the desired voucher. Please use the NOTES section to indicate which family members are to be issued a voucher. A listing of hearing aid providers who have agreed to provide our members with full hearing aid services at a reduced rate may be found on the Fund's website, www.csawf.org, under the Benefit Providers link on the left. Portions of the voucher must be completed by the member, the physician or audiologist and the hearing aid dealer. For direct reimbursement for services obtained from a non-participating provider, the completed claim form should be returned to the Fund office for processing and payment.

The claim form must be accompanied by a proof of purchase such as an itemized paid, receipted bill for the services provided.

*The person to whom the voucher is issued must, in all cases, sign the voucher in order for benefits to be provided. Unsigned vouchers will be returned for signature.*

# Home Health Aid Benefit

The Fund has established a Home Health Care benefit for members or dependents who require such services as certified by a physician. The purpose of this benefit is to provide necessary home care for members and/or eligible dependents who, on or after April 1, 2000, became incapacitated as result of injury or illness and who, as a result of that injury or illness, cannot perform at least two activities of daily living without assistance as certified by the patient's primary care physician. Services must be provided by a licensed home care agency or certified home health aide who is not related to the patient. No reimbursement will be made if the service provider is paid in cash unless there is a receipt signed by the provider. The benefit provides reimbursement to an annual maximum of $10,000 with a lifetime maximum of $30,000. Claims are paid at 80% after the annual Home Health Aide benefit deductible of $100 is met and will be based upon the Fund's determination of reasonable and customary charges.

A copy of the certified aide or agency's state certification and Taxpayer ID Number (TIN), either Federal employer number or individual social security number is required with the initial claim submission.

# Acupuncture Benefit

The Fund will reimburse 80% of out-of-pocket costs, for up to 36 treatments provided by a licensed acupuncturist. Requests for reimbursement must be submitted on a receipt showing the provider's name and address and state license number, as well as an itemized description of the service(s) provided, including procedure code and description, and amount charged for each service. If the provider is not state licensed (or lives in a state which does not license acupuncturists), he or she must be accredited by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and produce proof of accreditation. A maximum charge of $100 per visit is allowed.

# Supplemental Medical Benefits

The City health plan for retirees, under 65 years of age, and the combined program of Medicare and supplemental City coverage for retirees over 65 does not include coverage, or limits coverage, for certain medical services. The Fund will cover the cost of a selected number of these uncovered, or limited covered, services under a supplemental medical program. These expenses are subject to a $100 per patient annual deductible with reimbursement provided at 80% of reasonable and customary charges, up to a maximum of $5,000 per patient in benefits, per calendar year. Services covered in this benefit program are:

• Reimbursement of expenses for emergency ambulance services not fully reimbursed by the City basic health plan or Medicare.

• Reimbursement of ambulance/ambulette service which is not of an emergency nature when there is a medical necessity for such service and when such transportation can not be accomplished by public transportation, automobile, taxi, etc., due to the handicapping condition of the patient. The treating physician must provide a statement of medical necessity and eligibility for this service must be pre-approved by the Fund. Approval is subject to the discretion of the Trustees. There is an annual maximum of $2,500 applied to this non-emergency ambulance/ambulette reimbursement.

• The cost incurred for necessary casts, splints, orthopedic or orthotic devices for the feet (not including orthopedic shoes), not fully reimbursed by the City basic medical or Medicare program. Coverage for orthotic devices is limited to $400 per pair with a maximum of two sets of orthotic devices per patient per year.

• Wigs required as a result of loss of hair due to chemotherapy and/or radiation therapy or for those patients diagnosed with alopecia areata. The coverage for wigs is limited to a maximum of $1,000 per year.

• Reimbursement for surgical stockings is limited to a maximum benefit of $150 annually

• Nonpermanent or portable toilet seats, one per 12 month period

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# Supplemental Medical Benefits CONTINUED

• Therapy, including physical therapy, occupational therapy, and mental health counseling is covered for up to an additional $2,000 after the participant's primary insurance benefit has been exhausted. A statement from the primary insurance carrier stating benefits have been exhausted must be included with the first claim submission

• Co-payment charges incurred by members enrolled in any of the City provided HMO health plans such as the $25 co-pay costs for HIP/HMO out-patient psychiatric treatments or office visits to HMO doctors or services.

• The $300 patient deductible for hospital admission (imposed by the City health plan with a maximum of $750 deducted per calendar year)

• Expenses incurred by members enrolled in GHI/Blue Cross and not fully reimbursed by that plan for surgery (including invasive diagnostic procedures such as colonoscopies and bronchoscopies), anesthesia, radiation and chemotherapy costs (exclusive of drugs) whether in or out of a hospital are covered.

• Private Duty Nursing (by an RN, or LPN when an RN is not available, and when certified by the doctor as necessary) to an annual maximum of $10,000

• Costs associated with home infusion of antibiotics not covered by the primary health coverage, excluding the cost of medication. Costs for supplies and ancillary services are covered under this benefit, costs associated with administration of the medication through an intravenous port are covered under the private duty nursing benefit described above

• Prescription drug co-payments reimbursement for non-Medicare members enrolled in GHI for drugs obtained through the GHI drug program. Reimbursement is 80% after $100 RX deductible is satisfied, with a maximum of $10,000 annually. Medicare eligible members enrolled in GHI Senior Care with the optional rider as their Medicare D drug plan, or NYC Medicare Advantage Plus plan, are not reimbursed for prescription drug copays unless they exceed the applicable TrOOP (True Out Of Pocket) amount for that year. If the TrOOP maximum is exceeded, reimbursement is 100% of copays thereafter to a maximum reimbursement of $5,000. (Please refer to the Prescription Co-pay Reimbursement Guidelines below)

• Prescription drug co-payments of non-Medicare and Medicare eligible members enrolled in an HMO plan are reimbursed at 80% after the $100 RX deductible is satisfied with a maximum of $10,000 annually. (Please refer to the Prescription Drug Co-Pay Reimbursement Guidelines below)

• To file a claim for these services members should submit to the Fund a copy of the itemized bill, a prescription or statement of medical need by the doctor for the service, and a copy of the action taken by the basic health plan (GHl, Medicare, etc.) if any, in regard to that plan's reimbursement or denial of payment for that service

There are three (3) separate annual deductibles of $100 for home health aide, prescription drug co-payments and supplemental medical benefits.

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***GUIDELINES FOR PRESCRIPTION DRUG CO-PAY REIMBURSEMENTS AND CLAIM SUBMISSION***

# For Non-Medicare Retirees

Reimbursement of drug co-payment expenses is 80% after the annual $100 deductible, with an annual maximum of $10,000 for members enrolled in a City basic health plan with the optional rider for prescription drugs. This benefit is separate from the Fund's Supplemental Medical or the Catastrophic Medical benefit.

The above applies to eligible spouses (or registered domestic partners) who have **their own** prescription drug plan as well. Please submit a description of the spouse / partner's plan along with claim submission in order to facilitate determination of allowable benefit.

If the spouse is a retired UFT member with membership in SHIP, copayments are to be submitted to SHIP first. Kindly submit explanation of benefits or denial from SHIP for applicable coordination of benefits.

# GHI City Plan + Optional Rider

An Express Scripts Summary of Benefits is sent out quarterly from GHI. This statement is the only acceptable document used for processing. Please submit all 4 quarters at the end of the year. Processing takes place during March/April of following year.

# Emblem Health HIP or Other HMO City Plan + Optional Rider

• Submit printout from pharmacy or mail service used for purchases. The printout must include: total amount paid by insurance, name of drug, strength, quantity, date dispensed and amount paid by member.

• If a printout is not accessible, call the Fund to request receipt submission forms. Kindly paste or tape individual receipts from the pharmacy in chronological order. Please use a separate form for each patient. These receipts should also contain the information listed above.

• *Internet generated printouts will not be accepted*.

***PLEASE NOTE:***

**If the drug plan pays $0, the out of pocket cost is not considered a co-pay and there will be no reimbursement*

# For Medicare Retirees

***GHI SENIOR CARE + OPTIONAL RIDER (MEDICARE D ENHANCED PDP RX PLAN) ORNYC MEDICARE ADVANTAGE PLUS PLAN WITH OPTIONAL RIDER PRESCRIPTION DRUG PLAN***

• $480 automatic reimbursement to offset rider premium cost for one person in the family

• If out-of-pocket costs (TrOOP) exceeds yearly maximum, (ex: $4,550 – 2011), 100% reimbursement of additional co-pay costs with annual maximum of $5,000.

• For reimbursement of these costs, submit copies of all pages of the GHI ENHANCED MEDICARE PDP printouts including the first page (showing name and address of recipient), only when your TrOOP ("Amount You Paid" column) exceeds amount applicable for that year.

***GHI SENIOR CARE – NO OPTIONAL RIDER***

• No co-pay reimbursement/no premium reimbursement.

***GHI SENIOR CARE without Optional Rider + ANY OTHER MEDICARE D RX PLAN (for example, AARP)***

• Reimbursement of drug co-payment expenses at 80% after the annual $100 deductible, with an annual maximum of $5,000.

• Please submit description of drug plan for determination of allowed benefit along with pharmacy or mail service printout. The printout must include the plan's share of the cost of the medication.

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# For Medicare Retirees CONTINUED

***HIP/VIP Medicare Plan OR OTHER HMO Medicare CITY PLAN + OPTIONAL RIDER***

• HIP/VIP members must submit the Enhanced Medicare PDP Printout listing their prescription drug purchases. Other HMO Medicare plan participants must submit the printout from the pharmacy or mail service used for purchases. The printout must include: total amount paid by insurance, name of drug, strength, quantity, date dispensed and the amount you paid.

• If a printout is not accessible by the plan being used, call the Fund to request receipt submission forms. Kindly paste or tape individual receipts from the pharmacy in chronological order. Please use a separate form for each patient. These receipts should also contain the information listed above.

• *Internet generated printouts will not be accepted.*

***IMPORTANT:*** *If a CSA retiree has waived his/her City health plan and/or optional rider and is covered by a spouse/partner's plan, the Fund must have a detailed description of the plan being used for determination of benefit allowed. Medicare eligible members covered by another GHI-Senior Care City plan are not eligible for drug copay reimbursement unless they exceed the TROOP applicable for that year.*

# Survivors of Deceased CSA Retirees

***CITY COBRA + RIDER (Medicare & Non-Medicare)***

Reimbursement of drug co-payment expenses at 80% after the annual $100 deductible, with an annual maximum of $5,000.

***GHI***

Express Scripts Summary of Benefits or the GHI PDP printout that is sent from GHI. This statement is the only acceptable document used for processing. Submit each quarterly report as it is received throughout the year.

***HMO RX PLANS***

• Please submit printout from pharmacy or mail service used for purchases. The printout must include: total amount paid by insurance, name of drug, strength, quantity, date dispensed and amount you paid.

• If a printout is not accessible, call the Fund to request receipt submission forms. Kindly paste or tape individual receipts from the pharmacy in chronological order. Please use a separate form for each patient. These receipts should also contain the information listed above.

***Internet generated printouts will not be accepted.***

***OTHER MEDICARE SUPPLEMENTAL PLAN WITH RX BENEFITS***

Reimbursement of drug co-payment expenses at 80% after an annual $100 deductible, with an annual maximum of $5,000.

***OWN PLAN + RX PLAN- (Non-Medicare)***

• Reimbursement of drug co-payment expenses at 80% after an annual $100 deductible, with an annual maximum of $5,000.

• Please submit detailed description of the prescription drug plan being used for determination of benefit allowed.

# Catastrophic Stop Loss Benefit

***Members and/or Dependents enrolled in*** HMO***s***

Should a member or eligible dependent incur out-of-pocket expenses for covered services during a calendar year not provided by or fully reimbursed by the HMO, exclusive of hospital charges, the Fund will reimburse such expense at 80% until the Fund has reimbursed $1,000 after a $1,000 deductible has been met, thereafter the Fund's reimbursement will be at 100% to an annual maximum of $50,000. The annual lifetime benefit is $250,000 per person. Hospital charges are not considered a covered expense. HMO copayments are processed under the Supplemental Medical benefit.

Non-Medicare ***Eligible members and/or Dependents Enrolled in Emblem Health*** GHI

Should a member or eligible dependent use doctors who do not participate in the GHI program and, therefore, incur out-of-pocket expenses not reimbursed by GHI in excess of $1,000 during a calendar year for covered services, the Fund will provide reimbursement of such expense at 80% until it has paid $1,000. Thereafter, reimbursement will be made at 100% to an annual maximum of $50,000. Such reimbursement will be based on current reasonable and customary charges for necessary care and treatment. Included in the accumulation of the out-of-pocket costs are all deductibles and co-insurance charges applied by GHI, Blue Cross, and the Welfare Fund, exclusive of hospital charges other than the $300 per admission deductible. The annual lifetime benefit is $250,000 per person.

Medicare ***Eligible members and/or Dependents Enrolled in Emblem Health*** GHI

The Fund will provide the same benefit coverage as described above except that Medicare allowable charges will determine the Fund's reimbursement of expenses in excess of the $1,000 annual deductible. Charges in excess of Medicare guidelines will not be considered.

Effective January 1, 2006, expenses for medical services provided by providers who opted out of Medicare will be covered by the Fund's Catastrophic Medical benefit. The allowances for these services will be based on Medicare rates or 50% of the 50th percentile of Medicare allowable charges.

# Hospitalization Coverage

Coverage for hospitalization is provided by the basic City health plan for members enrolled in HIP-HMO or any of the other HMO plans offered by the City to its active or retired employees.

The City provided coverage for members enrolled in Empire Blue Cross and GHI/CBP provides hospitalization coverage for 365 days in full for retirees under 65 years of age. For retirees over 65 years of age covered by Medicare, extended coverage for 365 days plus other additional benefits such as coverage for prescription drugs is offered only through the purchase of an optional benefits rider. The CSA Retiree Welfare Fund has assumed the cost to the City to provide CSA Retirees enrolled in either GHI/CBP or GHI Type C with 365 days of hospitalization coverage. Members enrolled in either of these plans will automatically be covered for this benefit. Members who purchase the optional benefits rider will not be charged for the cost of the extended hospitalization part of the rider. They will only pay for the other benefits such as prescription drugs.

***Note: The Fund's coverage for extended hospitalization for the member and his/her eligible dependent can only be applied if the Basic Health Plan (GHI/CBP or C) is in the name of the CSA Retiree.***

# Survivors' Benefits

The CSA Retiree Welfare Fund provides surviving dependents continued coverage for a period of up to sixty months from the date of the member's death without cost to the surviving dependent. The coverage currently in effect; dental, optical, hearing aid and supplemental medical will be provided to surviving dependents without cost.

The dependent will not need to purchase this Welfare Fund coverage under the COBRA provisions. In order to receive supplemental medical benefits from the Fund however, the surviving dependent must obtain coverage from the basic City health plan under the City's COBRA provisions or have the equivalent coverage through another health plan.

Once the sixty months have expired, benefits may be extended for as long as the survivor elects to pay a monthly premium equivalent to the current COBRA premium.

Survivors are not covered for extended hospitalization benefits. This coverage is only available through the City health plan or other similar coverage.

Coverage by the Fund will be secondary to any other coverage the dependent may have through an employer or private paid plan and payment by the Fund will be coordinated.

A survivor will be considered an eligible dependent if the survivor is the legally married spouse or registered domestic partner of the deceased member, a dependent child under 26 years of age, A handicapped dependent child unable to sustain his or herself will be considered eligible without limitation to age provided that handicapping condition occurred prior to the dependent's 19th birthday.

Coverage will terminate sixty months after the date of the member's death, re-marriage or when a dependent's status terminates, whichever comes first if continued coverage arrangements have not been made.

# Legal Services Benefit

The Fund provides a legal services benefit free of charge to Fund participants and their families. The benefit is provided by the law firm of Feldman, Kramer, and Monaco (FKM) and provides several legal services at no charge, and others at a reduced fee. Wills, health care proxies, power of attorney documents are provided at no charge. Legal review and letter writing is also free of charge. Reduced fees are charged for more complex situations such as divorces and real estate closings.

***HOW TO USE YOUR LEGAL PLAN***

If you wish to consult a lawyer for benefits provided by the Legal Services Plan, the first step is to call the Legal Plan Attorney Office at 1 (800) 832-5182. An appointment will be scheduled for you, or you will receive a telephone consultation regarding your legal problem immediately.

You will be provided with legal services by attorneys employed or retained by the Legal Services Plan. There is no subscription or registration fee to be paid by any covered member to entitle him/her to the benefits of the Plan. In most instances, legal services are provided by a Plan employed or retained attorney. However, in special situations, (Member vs. Member dispute, for example) you will be provided with legal services by an attorney provided from a standby panel. Your relationship with the attorney will be that of attorney and client. No member of the Legal Services Plan, or any Trustee of the Legal Services Plan can interfere in this relationship. All protections of confidentiality between you and your attorney will be preserved.

As a covered member, you are not required to use the benefits provided by the Legal Services Plan. You are free, at all times, to hire your own attorneys, but the Plan will not pay your fees to a privately retained attorney, except if a voucher is available for the specific service. The Legal Services Plan will not absorb or be responsible for any part of the fees or charges of attorneys other than the Plan designated attorney, except as set forth herein. At all times, the Attorney's Code of Professional Responsibility and Ethics will fully apply to your relationship with your attorney. Neither your employer nor your union will receive any confidential information regarding your identity or your legal issues from the attorney unless you specifically in writing, authorize the attorney to release your information.

1. FREE CONSULTATION BENEFIT

A covered member or dependent may get telephone advice

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# Legal Services Benefit (continued)

or in-office/zoom consultations. This benefit provides a covered member and dependent with the opportunity to consult an attorney for three (3) one hour in-office sessions each calendar year concerning any new legal matter. In addition, a covered individual may consult with the Legal Service Plan attorneys an unlimited number of times over the telephone. The in-office consultations cannot be used as a credit toward any other service.

2. 24-HOUR EMERGENCY HOTLINE BENEFIT

If a covered member or dependent is confronted with a situation that requires immediate legal advice, he or she may call the emergency hotline to talk to an attorney after regular business hours. This emergency service may only be used in situations that cannot wait until the next business day, such as arrest, accident, or assault.

3. FREE DOCUMENT REVIEW BENEFIT

This benefit provides review and interpretation by an attorney of documents which directly involve the member or a covered dependent, such as guarantees, warranties, installment purchase agreements, loans, leases, and court papers.

The following documents are not included in the Document Review Benefit:

A. Tax Returns.

B. Work that is being prepared by other attorneys at the time of your Document Review appointment.

C. Documents exceeding 15 pages in length.

The Document Review Benefit provides review and interpretation of documents: it does not involve representation by counsel, unless such representation involves legal services covered by the Plan. If a covered matter is involved, the Plan will provide representation by an attorney in accordance with this Legal Services Plan.

4. FREE LEGAL LETTERS BENEFIT

Your Plan attorney will write free legal letters on your behalf to resolve legal or consumer disputes before they become lawsuits. These letters are available regarding any covered legal matter.

However, letters cannot be written in response to a pending lawsuit or regarding any personal injury claims, or in connection with any matter that in the sole discretion of the attorney, constitutes an impropriate, unethical or frivolous matter.

5. FREE LAST WILL AND TESTAMENT BENEFIT

This benefit provides a covered member and his/her spouse or registered domestic partner with the opportunity to have a Last Will and Testament executed under the supervision of a Legal Services Plan Attorney. Advice regarding estate planning and potential strategies to reduce estate taxes are included.

Wills include a Free Minor's Trust. A "Minor's Trust" is a trust that leaves property to a younger person, but in the care of a trustee, until the young person reaches a designated age, (often age 25, 30, or 35). Trusts for younger individuals are usually set up by parents or grandparents who want to leave property to a young person, but also want to name a trusted adult to care for the property until the child is mature enough to inherit in their own name.

It is sometimes important to protect this younger person from themselves. Often a parent or grandparent may wish that the child finish college and become financially responsible before the entire inheritance is distributed to that child. The minor's trust can also stagger the distributions from the estate thus potentially protecting the child from a divorce, a poor business decision or an accident.

6. FREE HEALTH CARE PROXY BENEFIT

This benefit provides a covered member and his/her spouse or registered domestic partner with the opportunity to have a Health Care Proxy prepared and executed under the supervision of a Legal Services Plan Attorney.

7. FREE LIVING WILL BENEFIT

This benefit provides a covered member and his/her spouse or registered domestic partner with the opportunity to have a Living Will prepared and executed under the supervision of a Legal Services Plan Attorney.

8.FREE DURABLE POWER OF ATTORNEY BENEFIT

This benefit provides a covered member and his/her spouse or registered domestic partner with the opportunity to have a Durable Power of Attorney prepared and executed under the supervision of a Legal Services Plan Attorney.

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# Legal Services Benefit (continued)

9. LEGAL PLAN WORKSHOPS BENEFIT

If there is enough interest, CSA may host workshops designed to educate members about the Legal Plan benefits. The seminars are basically pre-consultation estate planning workshops, tailored to motivate members to take advantage of the legal plan and prompt them to complete their estate planning documents. Members will be given the opportunity to sign up in advance for an appointment to meet with an attorney for FREE.

10. WILL AND ESTATE PLANNING PREPARATION WEBINAR BENEFIT

Members will have the opportunity to log on to a very user-friendly Will and Estate Planning Preparation webinar which will scheduled in advance.

11. WILL DAYS

If there is enough interest, CSA may host estate planning consultations at CSA Headquarters, or via Zoom, to motivate members to use their legal plan benefits, and prompt them to get their estate planning documents completed. On what are called "Will Days", eligible members will have the opportunity for a one-on-one consultation with an attorney. This attorney will educate members on how to complete their estate planning questionnaire, and overcome the pitfall of "out of sight, out of mind." Estate planning documents are then mailed to the member for review and then the member has an opportunity to sign up for a signing day wherein they will meet with the attorney again to ensure that the documents are executed properly.

12. ELDER LAW BENEFIT

Elder Law attorneys will consult with an eligible dependent to discuss asset preservation strategies. The first hour is free and all subsequent time will be billed at a 20% reduction from the Elder Law attorneys' usual billing rate. Elder Law is different than Estate Planning which is covered at no cost in the Last Will and Testament Benefit. Elder Law focuses on asset transfers which will protect assets in the event of the need for nursing home care. This service is also extended to member's parents or grandparents. Elder Law attorneys can advise on State law and assist in putting a health and estate plan in effect, which can maximize eligibility for coverage of nursing home and home care costs while preserving one's estate and assets. The attorneys who will provide the listed services specialize in the subject of Elder Law, estate planning, wills, trusts, pre-nursing home planning, probate, and conservatorship.

13. VETERANS BENEFIT

A Plan Attorney will assist a member or their parents with applying for the Veterans benefit, Aid and Attendance, which provides extra income for a veteran who requires medical care. They would extend this benefit to their spouse or domestic partner and their parents and parents-in-law.

14. STUDENT LOAN REDUCTION ASSISTANCE BENEFIT

Managing student loans and understanding the repayment options can be confusing and overwhelming, especially when you are getting unclear or conflicting information from your loan servicer. Members can speak with a Student Loan Counselor at no charge wherein they will receive a comprehensive review of their student loan issues. This includes government and private loan issues. Members will have access to assistance and advice in connection with the various student loan assistance programs. Based on their unique goals and circumstances, the Student Loan Counselor can analyze the available programs and design a comprehensive action plan. For a reduced fee they can also help complete program applications, submit required paperwork, answer legal questions, and troubleshoot bureaucratic problems related to student loan servicing.

15. REAL ESTATE BENEFIT

Purchase of Primary Residence $850; Sale of Primary Residence $850; Refinance of primary residence $275; Transfer of primary residence without consideration $275

16.PROMISSARY NOTE BENEFIT

PROMISSORY NOTE – Simple Promissory Note $75

17. DRIVING WHILE INTOXICATED BENEFIT

(First offense and up to two court appearances) $1,050

18. SMALL CLAIMS PROTECTION BENEFIT

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# Legal Services Benefit (continued)

Attorney will provide advice regarding the filing and pursuit of claims in Small Claims Court, including advice regarding procedure and evidence preparation for Small Claims Court matters. This benefit shall be limited to advice only.

19. IDENTITY THEFT BENEFIT

Attorney will provide advice regarding Identity Theft. They will provide advice to covered individuals on the federal laws governing identity theft and will offer covered individuals comprehensive advice on how best to avoid having their identity stolen. Victims of identity theft will be offered comprehensive advice and guidance on how best to proceed to reclaim their identity. This advice will include how to file a police report, what credit agencies to contact to place a fraud alert, and guidance on how to construct an appropriate dispute letter to any creditor or agency involved. This benefit shall be limited to advice only, and in appropriate limited circumstances may, in the professional discretion of the national legal office include the writing of up to three (3) letters per plan year

20. BANKRUPTCY BENEFIT

*Bankruptcy Chapter 11:* Attorneys will provide analysis and advise on the topic of bankruptcy and chapter 11 or other alternatives at the reduced hourly rate of $285 per hour.

*Bankruptcy Chapter 7:* $1,425 - This benefit includes a free consultation.

*Bankruptcy Chapter 13:* This benefit includes a free consultation and the availability of representation with petition filing at trial or in a court at the reduced hourly rate of $285 per hour.

21. FAMILY LAW BENEFIT

- Divorce (uncontested, without marital agreement) $900
- Divorce (uncontested, with marital agreement) $1,700
- Separation (Uncontested) $900
- Modification of Child Support (Preparation of pleadings only) $550

Additionally, the Plan provides coverage only to the covered member at the discounted hourly rate of $285 per hour in all stages of contested actions for divorce and separation and for annulment proceedings. This benefit also includes negotiation and preparation of separation agreements and property settlements. Plan attorneys will also represent the covered member in connection with the preparation of pre-marital contracts at the discounted hourly rate of $285 per hour. The Plan also covers representation of the covered member in support, family offense, custody, and paternity proceedings in Family Court at the discounted hourly rate of $285 per hour. These benefits only cover representation of the covered member. Dependents are not covered under these benefits.

22. REDUCED FEE BENEFIT

Representation is available from the Plan attorneys at the rate of $285.00 per hour for matters that are specifically covered by the Legal Plan but require payment for contested matters under the terms of the plan.

23. CRIMINAL DEFENSE BENEFIT

This benefit provides a covered member with consultation in connection with matters concerning any misdemeanor or felony. Representation is available from the Plan attorneys at $285.00 per hour. This benefit includes a free consultation and the availability of representation at trial or in court at the reduced hourly rate described herein or at a 30% reduction from the flat fee. Federal jurisdiction matters are not covered.

24. FORECLOSURE DEFENSE BENEFIT

This benefit provides a covered member with consultation in matters involving problems with a foreclosure in connection with the covered member's primary residence and regarding a petition which specifically names the covered member as a respondent. This benefit includes a free consultation and the availability of representation at a rate of $285 per hour.

25. PREVENTIVE LAW GUIDE BENEFIT –

The firm's newsletter provides timely information on a variety of consumer issues and is written to inform participants about their rights under the law. Designed to inform members of the benefits of the legal plan, including hot law related topics and how members can best use the legal plan

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# Legal Services Benefit (continued)

to protect their home and assets. Included will be success stories and examples on how members can utilize the legal plan to enhance their lives.

26. PERSONAL INJURY BENEFIT

Personal Injury cases are handled on a contingency fee basis. That means that the attorney fees are a percentage of the recovery rather than at an hourly rate. If there is no recovery you don't pay any legal fees. The law sets the percentage of the contingent fees and your plan has offered a reduction of that fee.

In the event that any covered member or dependent is injured in a car accident, slip and fall accident, dog-bite, product liability, premises accident, and others your Plan attorney will reduce the standard contingency fees approved by the court of the applicable state as follows:

Twenty percent (20%) reduction of the contingency fee if the case is settled prior to examination before trial.

Ten percent (10%) reduction of the contingency fee if the case is settled after examination before trial or is tried to conclusion.

This reduction can save an injured victim many thousands of dollars. Legal representation is available for medical or other professional malpractice. However, it is not possible to reduce the fees for those matters.

27. ESTATE ADMINISTRATION BENEFIT

Legal Representation in an uncontested probate of a Last Will and Testament or an uncontested estate administration proceeding in Surrogate's Court in the absence of a Will. The benefit allowance is a twenty-five (25%) percent reduction in the percentage contingencies used to calculate the statutory fiduciary commissions as outlined in the New York State Surrogate's Court Procedure Act, Section 2307 or New Jersey Surrogates Act, section 54: 34-5C. This includes the filing of Federal and State estate tax returns. Legal fees do not include court filing fees and expenses or disbursements that are chargeable to the client.

28. STOCK BROKER ARBITRATION BENEFIT

Elder financial abuse is on the rise and is expected to impact an increasing number of families across America over the next decade. Financial abuse cases arising out of Investment Fraud, Investment loss, Financial Adviser Misconduct, Account Churning, and accepted on a contingent fee basis by a participating referral attorney with a Ten percent (10%) reduction from the standard contingency fee approved by the court of the applicable state.

# Denial of Claims and Claims Review Procedure

In the foregoing pages, and in separate brochures describing the dental programs, specific instructions are furnished as to the proper procedure and time limitations for filing of claims. Where the benefit involved is furnished through an insurance carrier, the Fund aids in processing each claim but cannot overrule the findings of the carrier. In the event the insurance carrier rejects a claim, the claimant may request a review of the rejection. Such request for review is to be addressed in writing within 60 days of the notice of rejection to the insurance carrier and submitted to the CSA Retiree Welfare Fund office for forwarding. The Fund will assist and cooperate in obtaining a review and final decision by the carrier.

Where the benefit is not provided through an insurance carrier, and the claim is properly presented for processing, it is acted upon promptly and paid promptly. In the event that the Fund finds that the claim is incomplete or otherwise lacking in information, the claimant is promptly requested to furnish the necessary data. If a finding is made that the claim is improper or unjustified and is rejected, the claimant is notified of such rejection and the reason for such rejection is given. The claimant then has a right to request a review by submitting the request in writing, including the claimant's comments and the issues to be determined, to the Trustees of the Fund within 60 days of the date of rejection. In such event, the Trustees will review the claim at their next scheduled meeting and will render a decision following that meeting. The decision of the Trustees is final and binding on all parties. Please contact the Fund for appeal procedures and required documentation.

# General Information Concerning the Organization of the Fund

The Fund is administered by a Board of Trustees. It consists of six persons designated by the Council of School Supervisors and Administrators of the City of New York Local 1, AFSA, AFL-CIO. Members of the Board of Trustees can be communicated with by contacting them through the Fund office. The Board of Trustees governs the Welfare Fund in accordance with an Agreement and Declaration of Trust. The Board of Trustees employs an Administrator who is responsible for the day-to-day operation of the Fund.

The Administrator of the Fund has been designated as the agent for the service of legal process at the Fund's office – 40 Rector Street, 12th floor, New York, NY 10006. The Board of Trustees employer identification number is 112692902, the Plan number is 501-C(9). The fiscal year is October 1st to September 30th.

The Fund was established as a result of Collective Bargaining between the Council of School Supervisors and Administrators of the City of New York, Local 1, AFSA, AFL-CIO and the Department of Education of the City of New York located at 65 Court Street, Brooklyn, New York 11201. Contributions are predicated on the amount stipulated in the Collective Bargaining Agreements. Contributions are provided at annual rates, prorated monthly on behalf of each covered retiree. Retirees do not contribute. The Fund's assets and reserves are held in custody and invested by the Board of Trustees through various investments, savings and commercial banks.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies.

Dentcare (Healthplex) and Delta Dental underwrite prepaid Dental Programs described in this booklet.

All other benefits are self insured by the CSA Retiree Welfare Fund.

As someone who is eligible for benefits from this plan, you are no doubt aware of the fact that the benefits are paid in accordance with plan provisions out of a trust fund which is used solely for that purpose. If you have had any questions or problems as to benefit payments, as always, you have the right to get answers from the Trustees who administer the Fund.

As a participant in the CSA Retiree Welfare Fund, you are entitled to certain rights and protection provided by the Fund.

• You can obtain copies of all reasonable and appropriate plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

• You can receive a summary of the plan's financial report. The plan administrator will furnish each participant with a copy of the Fund's Summary Annual Report.

In addition to creating rights for plan participants, the Fund's trust agreement imposes duties upon the people who are responsible for the operation of the retiree benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under the trust agreement.

If your claim for a welfare benefit is denied in whole or in part, you will receive an explanation of the reason for the denial. You have the right to have the Fund review and reconsider your claim. If you are still dissatisfied, the Fund's supplementary agreement provides for resolution of such disputes through an arbitration procedure.

This booklet constitutes the plan of benefits of the Council of School Supervisors and Administrators Retiree Welfare Fund and, as such, includes the specific terms and conditions governing the coverage and the benefits provided by the Fund. In addition, there are various administrative policies and procedures which are applied on a uniform basis by the Fund and claimants will be informed whenever such policies and procedures are applied.

While this booklet describes the general features of the CSA Retiree Welfare Fund program for your information, it is not to be deemed a contract of insurance. The specific terms and conditions governing your coverage are set forth in the certificates of each basic plan. Where a specific program is not covered by insurance, your benefit programs are controlled by the rules and regulations of the CSA Retiree Welfare Fund then in effect.

# Plan Interpretations and Determinations

This booklet describes the main features of our plan. The Board of Trustees is responsible for interpreting the plan and for making determinations under the plan. In order to carry out their responsibility, the Board of Trustees, or their designee, shall have exclusive authority and discretion to: determine whether an individual is eligible for any benefits under the plan; determine the amount of benefits, if any, an individual is entitled to from the plan; interpret all of the provisions of the plan; and interpret all of the terms used in the plan. All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under the plan; be given deference in all courts of law to the greatest extent allowed by applicable law; and not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith.

# Statement of Privacy Practices

## Your Rights

*When it comes to your health information, you have certain rights. This explains your rights and some of our responsibilities to help you.*

| | |
|---|---|
| **Get a copy of your health and claims records** | • You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.<br>• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct health and claims records** | • You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.<br>• We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>• We'll consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not. |
| **Ask us to limit what we use or share** | • You can ask us not to use or share certain health information for treatment, payment, or our operations.<br>• We are not required to agree to your request, and we may say "no" if it would affect your care. |
| **Get a list of those with whom we've shared information** | • You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>• We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | • You can complain if you feel we have violated your rights by contacting us using the information on page 1.<br>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.<br>• We will not retaliate against you for filing a complaint. |

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# Statement of Privacy Practices CONTINUED

## Your Choices

*For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.*

**In these cases, you have both the right and choice to tell us to**

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission**

- Marketing purposes
- Sale of your information

## Other Uses And Disclosures

*How do we typically use or share your health information? We typically use or share your health information in the following ways.*

**Help manage the health care treatment you receive**

- We can use your health information and share it with professionals who are treating you.

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

**Pay for your health services**

- We can use and disclose your health information as we pay for your health services.

**Administer your plan**

- We may disclose your health information to your health plan sponsor for plan administration.

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# Statement of Privacy Practices CONTINUED

*How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.*

| | |
|---|---|
| **Help with public health and safety issues** | • We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | • We can use or share your information for health research. |
| **Comply with the law:** | • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests and work with a medical examiner or funeral director** | • We can share health information about you with organ procurement organizations.<br>• We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement, and other government requests** | • We can use or share health information about you:<br>• For workers' compensation claims<br>• For law enforcement purposes or with a law enforcement official<br>• With health oversight agencies for activities authorized by law<br>• For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | • We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

***Changes to the Terms of This Notice***

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Jan. 1, 2015. This Notice of Privacy Practices applies to the following organizations: CSA Welfare Fund.

# Administrative Fees

## Returned Mail

It is the member's responsibility to inform the Fund of address changes in a timely fashion. Each year hundreds of checks and other correspondence are returned to us because of invalid addresses. If you are routinely at an alternate address, please complete the available alternate address form and return it to the Fund. Notification of changes in address made to other organizations, such as the CSA Retiree Chapter, Teacher's Retirement System, or the City health plan in which you are enrolled does not automatically change your address with the Fund. As a result, there is a $2.00 charge for each piece of mail returned to the Fund.

## Miscellaneous Charges

Members will be held responsible for bank charges for checks returned due to insufficient funds, stop-payment orders, etc.

# Caution

This booklet and written material from the Trustees and the Fund's office personnel are your only authorized sources for plan information for you.