

**Plan Summary for  
Unified Court System  
Employees  
Represented by CSEA, Inc.**



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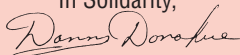
Dear Unified Court System Employees:

As Chairman of the CSEA Employee Benefit Fund, I am pleased to provide you with this booklet that contains important information on the benefits negotiated by CSEA and provided by the Fund.

Our goal is to encourage you to maintain your health and well-being by providing benefits that are carefully designed with you and your family in mind. Please take the time to read this booklet carefully to become familiar with your benefits.

I wish you every success and good health in the coming months and years.

In Solidarity,



Danny Donohue  
Chairman

## UNIFIED COURT SYSTEM EMPLOYEES

### GENERAL INFORMATION

#### Who Is Eligible

##### Full-Time Employee

- If you are a full-time employee in the Unified Court System bargaining unit represented by CSEA.

##### Part-Time Employee

- Part-time employees of the Unified Court System are entitled to the Unified Court System Dental Plan *only*.

**NOTE: An employee/retiree may not be covered both as an employee/retiree and as a dependent of an employee/retiree. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children may not be claimed under both.**

##### Dependents

- Your dependents become eligible at the same time you do. Dependents include:

##### *Spouse*

- Your spouse. This includes a person of the same sex to whom the covered employee was married in a jurisdiction permitting same sex marriages. A spouse can be removed upon entry into a legal separation. If you become divorced, **you must** remove your ex-spouse upon the finalization of divorce.

##### *Domestic Partners*

- 18 years of age or older
- Unmarried and not related by marriage or blood
- Residing together

- Involved in a committed (lifetime) rather than casual relationship
- Mutually interdependent financially

The Partners must be each other's sole domestic partner and must have been involved in the domestic partnership for a period of not less than 6 months. EBF members who wish to obtain benefits for their domestic partners are eligible to do so based on the same eligibility criteria and application process used for health insurance enrollment.

### **Children**

- Unmarried children under the age of 19, including legally adopted children, stepchildren and children of domestic partners, who permanently reside with you.
- Your legal ward under the age of 19 who permanently resides with you pursuant to a court order awarding legal guardianship to you and is supported by you and your spouse/domestic partner.
- Any child or ward described above, regardless of age, who is incapable of self support by reason of mental or physical disability, provided he or she became so disabled prior to reaching the age of 19.
- **Any child or ward described above under the age of 25 who is a full time student** (minimum of 12 undergraduate or 6 graduate credit hours) enrolled in a regionally accredited college or university and working toward a Bachelor Degree (e.g., B.A. or B.S.), Master Degree (e.g., M.A. or M.S.) or Associate Degree (e.g., A.A. or A.S.). Technical courses of short duration do not qualify, even if a diploma is awarded. The Fund requires that **current proof of student status be provided annually by completion of a Student Status form available from the CSEA EBF. Please visit our website at [www.cseaebf.com](http://www.cseaebf.com) or call 1-800-323-2732 to obtain a form.**

## **Enrollment**

### **Enrollment for New Employees**

There is a 28 day waiting period from the first day worked before your coverage becomes effective. Coverage under the plans offered by the CSEA EBF is not automatic. You must first enroll yourself and your dependents. When the CSEA EBF receives a notice of eligibility from the NYS Department of Audit and Control, a welcome packet is sent to the employee. In the packet there will be an enrollment form to complete. The enrollment form will ask you for your "N" Number from your pay stub and your Social Security Number. It is necessary for you to provide both full numbers to us. This will be the only time that your "N" number will be used.

Once the enrollment form is received in our office, the CSEA EBF will enroll you and your dependents if they are

listed. At that time, a CSEA EBF ID number will be sent to you for when you are using the CSEA EBF benefits.

Please note that in some circumstances, additional information for one or more of your dependents may be requested from you.

### **Enrollment Changes for Existing Employees**

If you have a change to your current enrollment, you will need to contact the CSEA EBF directly. A standard form is available for you to complete to add dependents. This enrollment form is available directly from CSEA EBF at **1-800-323-2732**. You can also visit our website, **www.cseaebf.com**, and download a form from there or use our Online Enrollment feature. Please note that in some circumstances, additional information for one or more of your dependent additions or deletions may be requested from you.

### **How to enroll a Domestic Partner**

- Members must contact their agency's Health Benefit Administrator (HBA) for an enrollment package.
- Your HBA will provide an approval notice to the CSEA EBF advising us of your eligibility to add a Domestic Partner along with the effective date of your partner's coverage.
- CSEA EBF will send you an enrollment form to complete and return to us which will provide us with the additional dependent information needed to enroll your partner under the coverage.

### **Transfer Employees**

- If you transfer into a CSEA bargaining unit from a State bargaining unit not covered by the Fund, there is a 28-day waiting period before coverage begins.
- Employees who were covered for vision coverage through the Fund under another employer must wait 12 months from their last service date before using the vision benefit under a new employer.
- If you transfer out of a unit covered by the Fund, you will be covered for 28 days after the last day worked. After this 28-day period, eligibility for coverage is terminated.

### **Status Change**

- Employees who change from part time status to full time status OR from full time status to part time status become eligible for coverage under the new status based on a date determined by the Unified Court System.

### **Continuation of Coverage**

#### **Resignation or Termination**

- You are covered for 28 days after the last day worked. Unless you elect the COBRA option, your eligibility terminates after this 28-day period.

- If you die, or become divorced or legally separated, or a dependent ceases to be a dependent, your spouse and/or dependent may have certain rights to continue Plan coverage through COBRA. In the event of divorce, legal separation or a child losing dependent status, you or a family member must inform the Fund of the qualifying event within 60 days of the event or the day on which coverage would be lost because of the event.

### **Abuse or Misuse**

- **Abuse or misuse of any Plan may result in withholding of benefits.**
- The Fund reserves the right to revoke assignment of benefits to certain providers.

## **VISION CARE PLAN**

The Vision Care Plan offers quality eye care services at no cost to members when using one of the Plan's panel providers.

### **Using This Benefit**

When in need of Vision Care services, call the Employee Benefit Fund at **1-800-323-2732** to determine if you are eligible for benefits. Make an appointment with a participating provider who will then obtain an authorization for services from the Fund. A list of over 3,000 participating providers will be provided to you on request.

### **Using a Participating Provider**

#### **General Benefit Provisions**

Eligible members and dependents are entitled to a routine eye examination and one pair of glasses or a contact lens benefit once every 12 months.

Dilation will be included at a **Provider's Office** whenever **professionally indicated** without any additional cost to the member.

#### **Eyeglasses**

The benefit includes progressive addition no-line bifocals or trifocals, cataract lenses, scratch proofing, glass photo-chromic, high index lenses, fashion tints and prescription sunglasses.

If you go to a participating vision provider and select a frame from your plan collection, you will have no out-of-pocket expense for the cost of your frame. If you choose a frame that is outside of your plan collection, you will be provided a \$30 allowance and you must pay the difference in the price to the participating provider.

## Contact Lenses

- Plan contact lenses consist of soft planned replacement or disposables. You will be allowed \$125 toward non-plan contacts.
- A Contact Lens Formulary is used which allows for an initial supply\* of many of the most popular and commonly prescribed brands of soft contact lenses. If non-plan contact lenses are required, the allowance will be applied **toward** the total cost of the contact lenses.

\*Duration of initial supply may vary depending on the lens type, wearing habits and prescribing doctor's instruction regarding replacement schedule.

## VISION DISCOUNT FIXED CO-PAYS

### Major Plan Features

- Program offers fixed co-pays for lenses and coatings at any EBF participating provider office.
- Members/eligible dependents who wish to purchase lenses and coatings not currently covered by their vision program will be entitled to a set co-pay, resulting in substantial out-of-pocket savings.

### Fixed Co-pays Include:

- \$35.00 – Standard Anti-reflective Coating
- \$48.00 – Premium Anti-reflective Coating
- \$55.00 – Ultra Anti-reflective Coating
- \$12.00 – Ultraviolet (UV) Coating
- \$65.00 – Plastic Photosensitive Lenses
- \$50.00 – Ultra Progressive Lenses
- \$75.00 – Polarized Lenses

This valuable program provides savings to members resulting in less out-of-pocket for “add ons.”

### How to Use This Benefit

- Use any CSEA Employee Benefit Fund **participating** vision provider. For a list of providers, please visit our website at **[www.cseabf.com](http://www.cseabf.com)**.
- Members who choose lenses and/or coatings not covered in their existing EBF vision plans will pay the fixed co-pay in the schedule listed above.

### Limitations And Exclusions

- Patient must be covered by the Fund under an existing vision program to be eligible for fixed co-pay(s). This discount is available only at the time of the eligible date of service. It is not available as a separate service outside of the patient's eligibility date.
- All portions of the benefit (exam plus corrective wear) must be billed simultaneously. All services must be performed on the same day. Benefits cannot be split between two panel providers OR between a participating and non-participating doctor.

- Any benefit that is claimed after a period that exceeds one year from the calendar year in which vision services were rendered.
- Please note: fixed co-pays are not refundable. Payment for items not covered under the plan are the responsibility of the patient.

## Using a Non-Participating Provider

When you choose to receive services from someone who does not participate as a CSEA Panel Provider, an indemnity payment will be made directly to you for expenses, not to exceed:

Exam .....	\$ 16
Frame .....	\$ 11
Standard Lenses .....	\$ 14
Bifocals .....	\$ 23
Trifocals .....	\$ 32
Photochromic .....	\$ 12
Contact Lenses .....	\$125

Substantial out-of-pocket expenses can be avoided by using CSEA Vision Care Panelists. Contact the Fund for a claim form or visit our website at [www.cseaebf.com](http://www.cseaebf.com)

**Send all vision correspondence to:  
CSEA EMPLOYEE BENEFIT FUND  
P.O. Box 516  
Latham, NY 12110-0516**

## DENTAL CARE PLAN

### How To Use This Plan

- You may use any licensed dentist for dental care.
- The Fund contracts with participating dental offices to accept the fee schedule as payment in full for covered dental services whether payment is made by you or the Fund.
- If you would like to view our current Directory of Dental Care Providers, you can request a copy by calling us at **1-800-323-2732** or visit our website at [www.cseaebf.com](http://www.cseaebf.com).
- Specialists within participating general practices have the right to bill members for the difference between the specialist's customary charge and the allowance which the CSEA Employee Benefit Fund pays under the UCS Dental Plan. The Specialist must inform the Fund and the member that he/she will not be accepting the plan allowance as payment in full and must provide proof of specialty status to the Fund.
- If you choose a non-participating provider, and are charged more than the amount listed under the Schedule of Allowances, you must pay the difference.



- A universal American Dental Association (ADA) claim form, available through your dental provider, or a CSEA claim form which may be obtained from our website, [www.cseaebf.com](http://www.cseaebf.com), must be used to submit for completed services. Electronic claims are also accepted.
- **The Fund does not recommend that you use any particular dentist, either participating or nonparticipating.**

**SUBMIT ALL DENTAL CLAIM FORMS TO:  
CSEA EMPLOYEE BENEFIT FUND  
P.O. Box 489  
Latham, NY 12110-0489**

### **Maximum Benefit Dental Plan**

- There is a \$3000.00 annual maximum dental benefit for each covered member and dependent.
- For year 2014 and on, there is no annual maximum for children under the age of 19, per the Affordable Care Act guidelines.
- This maximum is on a calendar-year basis (January through December).
- Under this maximum, the Benefit Fund is assuming liability for up to the first \$3000.00 of covered dental work per year. This maximum does not apply to orthodontics, implant body placement, implant abutments, prophylaxis or oral evaluations.
- We encourage those about to undergo extensive dental treatment to discuss those plans with the dentist beforehand. There are often less expensive alternatives available which will provide high quality dental care.

### **Appeal Procedure**

- If you feel that you did not receive full benefits, you may appeal to the Fund. Please call customer service at 1-800-323-2732 and request a dental claim appeal form which can be emailed or mailed to you. Include copies of supporting documentation.
- ALL appeals must be submitted within 60 days of the determination being appealed.
- Please note the appeal process could take up to 4-6 weeks.
- This appeal procedure is not designed to cover services not covered by the Plans.

### **Pre-Authorization of Benefits**

- Whenever the estimated cost of a recommended dental treatment exceeds \$500.00, we advise the submission of a pre-authorization before the work begins.

- Use a dental claim form for this submission and include the related x-rays.
- After review, the Benefit Fund will notify the member and the dentist of the benefits payable based upon the treatment plan.
- In determining the amount of benefits payable, consideration will be given to alternate procedures that will accomplish a professionally acceptable result.
- If the member and the dentist agree to a more expensive method of treatment than that pre-authorized by the Benefit Fund, the amount exceeding the pre-authorization will not be paid by the Fund even if it would otherwise be a covered service. If we recommend alternate benefits, you should also discuss this with your dentist.
- For Example: If your dentist submitted a pre-authorization for a crown which would cost \$675.00 and review by our dental consultant showed that an amalgam restoration for \$130.00 would give an acceptable result, the Benefit Fund would pay only \$130.00. If the member decided to have the crown, he or she would pay the difference of \$545.00. (\$675.00 - \$130.00)

**A pre-authorization is not a guarantee of benefits. Payment is always subject to eligibility at the time of service.**

## **UNIFIED COURT SYSTEM DENTAL PLAN SCHEDULE OF ALLOWANCES FOR COVERED SERVICES**

### **DIAGNOSTIC SERVICES**

**CONSULTATION** (1 per calendar year)..... \$100.00

### **CLINICAL ORAL EVALUATION (EXAMINATION)**

**Evaluation – periodic, comprehensive, limited or detailed** 3 evaluations per calendar year (outside annual maximum)..... \$ 38.00

### **DENTAL RADIOGRAPHS**

**Intraoral complete series including bitewings** (1 per 3 years)..... \$ 85.00

or

**Panoramic** (1 per 3 years) ..... \$ 85.00

*There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the the same 12 month period as a panoramic image.*

**Periapical x-ray, each image** (Maximum 10 per calendar year)..... \$ 8.00

**Bitewing x-ray, each image** (Maximum 4 per calendar year)..... \$ 10.00

**Occlusal image**(2 per 3 years)..... \$ 25.00

**Cephalometric film** (1 per calendar year)..... \$ 85.00

### **TESTS AND LABORATORY EXAMINATIONS**

**Pulp vitality test** (1 per tooth per calendar year).... \$ 20.00

## PREVENTIVE SERVICES

<b>Dental prophylaxis, adult-12 years and over</b> <i>3 per calendar year (outside annual maximum)...</i>	\$ 75.00
<b>Dental prophylaxis, child-under 12 years</b> <i>(3 per calendar year) .....</i>	\$ 60.00
<b>Fluoride, child-under 19 (2 per calendar year) ..</b>	\$ 16.00
<b>Sealants, child-under 19, per tooth, covered on</b> <i>bicuspid and molars in the permanent dentition only</i> <i>(1 per 3 years).....</i>	\$ 22.00
<b>Space maintainers, child-under 19</b> <i>(1 per tooth per lifetime)</i>	
<b>Unilateral space maintainer.....</b>	\$ 78.00
<b>Bilateral space maintainer.....</b>	\$144.00

## RESTORATIVE - FILLINGS

**AMALGAM RESTORATIONS** *(1 per each surface per tooth per 12 month period). Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.*

### PERMANENT OR PRIMARY TEETH

<b>Amalgam, one surface .....</b>	\$ 88.00
<b>Amalgam, two surfaces.....</b>	\$110.00
<b>Amalgam, three surfaces .....</b>	\$130.00
<b>Amalgam, four or more surfaces .....</b>	\$130.00

**RESIN-BASED COMPOSITE RESTORATIONS** *(1 per each surface per tooth per 12 month period). Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.*

### PERMANENT OR PRIMARY TEETH *(Anterior or Posterior)*

<b>Resin-based composite, one surface .....</b>	\$ 95.00
<b>Resin-based composite, two surfaces .....</b>	\$120.00
<b>Resin-based composite, three surfaces .....</b>	\$150.00
<b>Resin-based four or more surfaces</b> <b>or involving incisal angle .....</b>	\$150.00

## RESTORATIVE - CROWNS AND INLAYS/ONLAYS

- Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling.
- The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan.
- Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation.
- Benefits are payable upon insertion of the crown or inlay/onlay.
- **Pre-op radiographs are required for the review of this procedure.**

**CROWNS** (1 per 5 years)

<b>Resin</b> (permanent, anterior teeth only) .....	\$180.00
<b>Resin fused to metal</b> .....	\$370.00
<b>Porcelain/Ceramic</b> .....	\$675.00
<b>Porcelain fused to metal</b> .....	\$675.00
<b>3/4 cast metal</b> .....	\$430.00
<b>Full cast metal</b> .....	\$500.00

**IMPLANT/ABUTMENT SUPPORTED CROWNS** (1 per 10 years)

<b>Implant/abutment supported, porc/ceramic</b> .	\$675.00
<b>Implant/abutment supported, porcelain fused to metal</b> .....	\$675.00
<b>Implant/abutment supported, full cast metal</b> ...	\$500.00

**INLAYS/ONLAYS** (1 per 5 years)

<b>Inlay/onlay, one surface</b> .....	\$250.00
<b>Inlay/onlay, two surfaces</b> .....	\$370.00
<b>Inlay/onlay, three or more surfaces</b> .....	\$382.00

**OTHER RESTORATIVE SERVICES**

<b>Recement Inlay</b> (1 per calendar year).....	\$ 20.00
<b>Recement Crown, Implant Crown</b> (1 per calendar year).....	\$ 30.00
<b>Stainless steel crowns, deciduous teeth only</b> (1 per tooth per 5 years) .....	\$ 56.00
<b>Core buildup, per tooth including pins</b> (1 per lifetime) .....	\$ 65.00
<b>Pin retention, per tooth</b> (1 per calendar year) .....	\$ 20.00
<b>Post and core, cast or prefabricated, per tooth</b> (1 per 5 years) .....	\$120.00

**ENDODONTICS****ROOT CANAL THERAPY** (1 per tooth per lifetime)

*Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.*

<b>Root canal therapy, anterior</b> .....	\$495.00
<b>Root canal therapy, bicuspid</b> .....	\$625.00
<b>Root canal therapy, molar</b> .....	\$775.00

**OTHER ENDODONTIC/PERIRADICULAR SERVICES**

<b>Pulp capping, direct or indirect</b> (1 per tooth per calendar year).....	\$ 20.00
<b>Pulpotomy, deciduous teeth only</b> (1 per tooth per lifetime) .....	\$ 55.00
<b>Apicoectomy, 1st root</b> (1 per tooth per lifetime) .....	\$400.00
<b>Apicoectomy, each additional root</b> .....	\$125.00
<i>(General Anesthesia /IV sedation covered with apicoectomy)</i>	
<b>Retrograde filling, per root, in conjunction with apicoectomy</b> (1 per tooth per lifetime) .....	\$100.00

**PERIODONTICS**

*Gingivectomy, Osseous Surgery and Bone Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and*

limitations of the Plan. **The treatment plan must be accompanied by x-rays and periodontal charting.** Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity.

<b>Gingivectomy or gingivoplasty, per quadrant</b> (1 per 4 years).....	\$320.00
<b>Osseous surgery, per quadrant</b> (1 per 4 years).....	\$625.00
<b>Bone replacement graft, per tooth (D4263)</b> (2 per calendar year) .....	\$250.00
<b>Periodontal scaling and root planing, per quadrant (2 per calendar year) limited to 2 quadrants per visit.....</b>	\$ 90.00
<b>Periodontal maintenance procedure</b> 3 per calendar year (outside annual maximum), either prophylaxis or periodontal maintenance procedure .....	\$ 75.00

## **PROSTHODONTICS (REMOVABLE)**

A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next **5 or 10** year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.

**COMPLETE DENTURES** (1 per 5 years)  
Full upper or lower denture, permanent..... \$700.00

**PARTIAL DENTURES** (1 per 5 years)  
Partial upper or lower denture, permanent.. \$700.00

Unilateral partial upper or lower  
denture, permanent..... \$300.00

**IMPLANT/ABUTMENT SUPPORTED DENTURES** (1 per 10 years)  
Implant/abutment supported full  
upper or lower denture, permanent..... \$700.00  
Implant/abutment supported partial  
upper or lower denture, permanent..... \$700.00

**ADJUSTMENTS TO DENTURES**  
Full or Partial Denture adjustment after 6 months of  
insertion of denture (1 per calendar year) .....\$ 30.00

**REPAIRS TO FULL/COMPLETE DENTURES**  
Replace missing or broken teeth  
(limited to 4 per calendar year) ..... \$ 50.00

**REPAIRS TO PARTIAL DENTURES**  
Repair, replace or add clasp to existing partial

<i>(limited to 4 per calendar year)</i> .....	\$ 71.00
<b>Replace or add tooth to existing partial</b> <i>(limited to 4 per calendar year)</i> .....	\$ 50.00
<b>REBASE FULL DENTURE</b> <i>(1 per 2 years)</i>	
<b>Rebase-upper or lower</b> .....	\$169.00
<b>RELINE OF DENTURES</b> , Upper or Lower <i>(1 per 2 years)</i>	
<b>Reline full denture</b> .....	\$154.00
<b>Reline partial denture</b> .....	\$154.00

## PROSTHODONTICS (FIXED)

*Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.*

### PONTICS *(1 per 5 years)*

<b>Cast metal</b> .....	\$425.00
<b>Porcelain fused to metal</b> .....	\$525.00
<b>Porcelain/Ceramic</b> .....	\$525.00
<b>Resin fused to metal</b> .....	\$346.00

### ABUTMENT CROWNS FOR FIXED BRIDGE RETAINERS

*(1 per 5 years)*

<b>3/4 Cast Metal</b> .....	\$430.00
<b>Full Cast Metal</b> .....	\$500.00
<b>Porcelain fused to metal</b> .....	\$675.00
<b>Porcelain/Ceramic</b> .....	\$675.00
<b>Resin fused to metal</b> .....	\$370.00
<b>Retainer for Maryland Type Bridge</b> .....	\$235.00

### IMPLANT/ABUTMENT SUPPORTED CROWNS FOR FIXED BRIDGE RETAINERS *(1 per 10 years including pontics part of implant fixed bridge retainer)*

<b>Implant/abutment supported, cast metal</b> .....	\$500.00
<b>Implant/abutment supported, porcelain fused to metal</b> .....	\$675.00
<b>Implant/abutment supported, porc/ceramic</b> .....	\$675.00

### OTHER FIXED PARTIAL DENTURE SERVICES

<b>Recent Bridge, Implant Bridge</b> <i>(1 per calendar year)</i> .....	\$ 50.00
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## ORAL SURGERY

### EXTRACTIONS *(1 per tooth per lifetime)*

<b>Extract coronal remnants, primary tooth</b> .....	\$ 80.00
<b>Erupted tooth or exposed root</b> .....	\$100.00
<b>Surgical removal</b> .....	\$140.00
<b>Soft tissue impaction</b> .....	\$230.00
<b>Partial bony impaction</b> .....	\$250.00
<b>Full bony impaction</b> .....	\$315.00
<b>Surgical removal of residual roots</b> .....	\$140.00

### OTHER ORAL SURGICAL PROCEDURES

#### **Surgical Placement of Implant Body (D6010: 1 per tooth position per 10 years)**

- An allowance will be provided for the surgical

placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.

- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the \$1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-only) placed within the last 5 years and is/are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.
- Implant/Abutment Supported Prosthetics (Removable Dentures, Fixed Dentures, Fixed Partial Dentures/ Retainers & Single Crowns) will be subject to a 10 year replacement rule.
- Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.
- Implant Body (*per tooth position*) ..... \$1,000.00  
(*2 teeth per calendar year*)

**Surgical access of unerupted tooth**

(*1 per tooth per lifetime*) ..... \$120.00

**Supporting Structures** (*1 per tooth position per 10 years/2 per calendar year*)

Prefabricated Abutment (D6056) ..... \$250.00

Custom Abutment (D6057) ..... \$250.00

- A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the implant abutments will be outside of the member's annual plan maximum.

**Bone Graft at time of implant placement**

(*1 per tooth position per 10 years / 2 per calendar year: D6104*) ..... \$350.00

**Biopsy of oral tissue, hard or soft, tissue removal** ..... \$120.00

**Alveoloplasty, per quadrant, in conjunction with extraction** (*1 per lifetime*) ..... \$135.00

**Alveoloplasty, per quadrant, not in conjunction with extractions** (*1 per 5 years*) ..... \$100.00

**Incision and drainage** (intraoral) ..... \$125.00  
(*1 per calendar year*) (*General anesthesia/IV sedation not covered with this procedure*)

**Frenulectomy** ..... \$200.00

**Excision of Lesion** (*1 per calendar year*) ..... \$200.00

**Bone replacement graft for ridge preservation**  
(1 per tooth per lifetime / 2 per calendar  
year: D7953)..... \$250.00

## **ORTHODONTICS**

*Provided for employees, spouses and unmarried dependent children enrolled in the plan. This plan covers adult orthodontics.*

*If a cosmetic upgrade (ex. invisalign or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.*

**Limited/Interceptive/Appliance Therapy** ..... \$300.00  
(once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)

**Comprehensive orthodontic treatment, appliance insertion** (once per lifetime) ..... \$808.00

**Periodic orthodontic treatment visit** ..... \$125.00  
(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.)

**Passive Treatment (for cases started after 01/01/14)**  
(one treatment benefit per lifetime following comprehensive treatment, includes retainers).. \$300.00

## **ADJUNCTIVE GENERAL SERVICES**

**General anesthesia/deep sedation-each 15 minute increment with a maximum benefit of \$200.00**  
(per covered oral surgery visit) ..... \$100.00

**or**

**Intravenous sedation -each 15 minute increment with a maximum benefit of \$200.00**  
(per covered oral surgery visit) ..... \$100.00

**Palliative (emergency) treatment of dental pain**  
(2 per calendar year) ..... \$ 50.00

**Occlusal adjustment, limited**  
(1 per 4 years)..... \$ 50.00

**Occlusal adjustment, complete**  
(1 per 4 years)..... \$175.00

## **EXCLUSIONS AND LIMITATIONS**

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- There is coverage for replacement of an existing crown, partial or full removable denture or replacement of fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to the bridgework to replace extracted natural teeth, but only if the Plan is furnished satisfactory evidence that:



- (a) The existing denture or bridgework was inserted at least **five** years prior to its replacement and that the existing denture or bridgework cannot be made serviceable by a dentist, or
- (b) In the case of a crown, that at least **five** years has elapsed since the crown was inserted, or
- (c) The existing implant supported crown, bridge, or denture was inserted at least **ten** years prior to its replacement and that the existing implant supported crown, bridgework or denture cannot be made serviceable by a dentist.

**In addition to the Exclusions and Limitations as stated in the CSEA EBF UCS Dental Plan Schedule of Allowances and those listed above, THIS PLAN DOES NOT COVER:**

- charges for any type of service or appliance not described in schedule of allowances
- treatment by other than a licensed dentist or dental hygienist acting within the scope of licensure
- services and supplies that are primarily cosmetic in nature
- replacement of **lost** or **stolen** prosthetic appliance
- duplicate prosthetic appliances or services
- dentures, crowns, inlays, bridgework or appliances to change or maintain vertical dimension
- precision or other elaborate attachments or features for dentures, bridgework or any other dental appliances
- any service rendered or appliance furnished before the eligibility date or after the termination date under this Plan
- splinting
- mini implants
- treatment covered by Workers' Compensation or similar law
- charges for expenses which are reimbursable through "no-fault" automobile insurance
- any claim or appeal that is submitted after a period that exceeds one year from the calendar year in which dental services were rendered
- temporary dental services which will be considered an integral part of the final dental service rather than a separate service

**Coordination of Benefits**

Since it is not intended that the patient receive greater benefits than the actual expenses covered, the amount of benefits payable under the UCS Dental Plan will take into account any coverage the employee (or eligible dependent) has under other group plans. In other words, the benefits under the UCS Dental Plan will be

coordinated with the benefits of other group plans.

**Note: An employee/retiree may not be covered both as an employee/retiree and as a dependent of an employee/retiree. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children may not be claimed under both.**

### **Birthday Rule**

Coordination of benefits regulation states that the primary payer of benefits for dependent children is determined by the parent who has the earlier birth date by month and day, without regard to year of birth. (other determining factors may apply)

## **LEGAL SERVICES BENEFIT**

### **MAJOR PLAN FEATURES**

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- Provides assistance with meeting legal expenses.
- Members are free to choose any attorney according to individual needs and type of case.
- Reimbursement sent directly to the member.
- Many services also cover the eligible dependents.

### **HOW TO USE THIS BENEFIT**

Visit [www.cseaebf.com](http://www.cseaebf.com) to download a legal claim form. After legal services are completed, fill out parts 1 and 2. Attach a signed statement from your attorney specifying services rendered, date completed, fees charged, and then mail it to the EBF at the address below.

Canceled checks, retainer agreements and payment ledgers are not accepted. All claims must be submitted no later than December 31st of the following year. The reimbursement will be sent directly to the member.

CSEA Employee Benefit Fund  
P.O. Box 516  
Latham, New York 12110-0516  
[www.cseaebf.com](http://www.cseaebf.com) | 1-800-323-2732

### **LEGAL PLAN BENEFIT SUMMARY**

#### **Adoption:**

##### ***Who is eligible***

Member who seeks representation in an adoption proceeding.

##### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal advice and representation in an adoption proceeding, either as adoptive parent or natural parent.

**Benefit allowance**

Up to \$300.

**Limitations**

Benefit allowance does not cover the payment of any fees or expenses to adoption or other agencies.

**Arraignment Service****Who is eligible**

Member or dependent, as defined by the EBF, who is a defendant in a criminal arraignment proceeding which does not involve a traffic related matter.

**What is the benefit**

Reimbursement for attorney fees up to the EBF fee schedule allowance related to representation in an arraignment proceeding requiring a personal appearance by legal counsel.

**Benefit allowance**

Up to \$150.

**Limitations**

Costs of legal representation beyond the arraignment stage are not covered. Thus, should a covered member or dependent desire to retain an attorney beyond the arraignment stage, such individual must make necessary fee arrangements directly with the attorney of choice. This arraignment service does not cover arraignments on traffic related matters.

**Automobile Defense Overage Matters:****Who is eligible**

Member or dependent as defined by the EBF, who is a defendant in an action involving an on road vehicle.

**What is the benefit**

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal services for the defense of an action involving operation of a vehicle wherein damages or personal liability exceed face amount of insurance policy.

**Benefit allowance**

Up to \$300.

**Limitations**

Overage cases only: That is a suit for damages that would exceed the face amount of the insurance policy. Legal representation provided by insurance companies is not reimbursable.

**Change of Name:****Who is eligible**

Members and dependents are entitled to this benefit.

**What is the benefit**

Reimbursement for attorney fees up to the EBF

fee schedule allowance related to legal advice and representation in a change of name procedure. Change may be of first name, middle name or last name, or any combination.

***Benefit allowance***

Up to \$200 per family per lifetime.

***Limitations***

Limited to one change of name sought by member for self and dependents, per lifetime.

**Contracts:**

***Who is eligible***

Member or spouse who seeks to obtain legal services regarding a non-business contract.

***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal advice and/or representation in the preparation and execution of a personal, non-business contract.

***Benefit allowance***

Up to \$75.

***Limitations***

Does not provide allowances for the preparation and execution, or review of business contracts.

**Court-Ordered Support:**

***Who is eligible***

Member or spouse who is involved in an action for support, modification of an existing support order, or an enforcement proceeding concerning a support order, provided, however, that if the action or proceeding is between the member and the spouse, no benefit shall be payable to the spouse.

***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal advice and representation in a court proceeding to award or modify support payments, or to commence or defend contempt or enforcement proceedings.

***Benefit allowance***

Up to \$200 maximum per calendar year.

***Limitations***

Covers only proceedings NOT commenced in conjunction with a divorce, separation or annulment.

**Debt Collection Defense:**

***Who is eligible***

Member or dependent as defined by the EBF, who is a defendant in a claim involving debt collection.

***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to defense in a legal action started against the defendant involving their rights in resisting a claim before District, City, Civil, County or Supreme Courts. For claims which are asserted in Courts outside New York, the EBF will determine the applicable benefit allowance.

***Benefit allowance***

Without trial, District, City or County Court...  
Up to \$150.

Without trial, Civil or Supreme Court...  
Up to \$250.

With trial, District, City or County Court...  
Up to \$300.

With trial, Civil or Supreme Court...  
Up to \$500.

***Limitations***

Only one debt collection defense allowance is permitted per calendar year.

**Domestic Relations Representation:*****Who is eligible***

Member involved in a separation, annulment or divorce requiring legal representation.

***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to representation by an attorney in a separation, annulment or divorce proceeding.

UNCONTESTED matters are those resolved up to and including a pre-trial conference.

CONTESTED matters are those not settled at the pre-trial conference but settled prior to an actual court trial.

LITIGATED matters are those resolved only after a Supreme Court trial commences and include any referral to and representation at Family Court.

***Benefit allowance***

UNCONTESTED Legal Separation, Annulment or Divorce... Up to \$300.

CONTESTED Legal Separation, Annulment or Divorce... Up to \$400.

LITIGATED Legal Separation, Annulment or Divorce... Up to \$500.

***Limitations***

Allowances may be reduced if court awards payment of

attorney fees or portions thereof. Combination of award and benefit may not exceed fees charged.

## **Estate Settlement Matter:**

### ***Who is eligible***

Member or dependent as defined by the EBF who is a named distributee, named beneficiary or named fiduciary to an estate.

### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to a preliminary legal consultation in connection with the probate or settlement of an estate.

### ***Benefit allowance***

Up to \$20.

### ***Limitations***

As Fees are generally set as a percentage of the estate no benefit allowance is payable other than a \$20 consultation benefit.

## **General Consultation:**

### ***Who is eligible***

Member or spouse obtaining an in-person legal consultation with an attorney regarding an actual or assumed personal legal problem.

### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance for up to five, one half hour sessions on separate dates, each calendar year, concerning unrelated legal questions.

### ***Benefit allowance***

\$20 per visit to an attorney's office.

### ***Limitations***

Business matters, excluded matters and telephone consultations are not covered. When an attorney is retained to provide a specific service for which benefit allowances are provided for by other provisions in this Plan by the EBF, the initial general consultation, as well as all other general consultations related to that matter, are not covered by this provision.

## **Juvenile Delinquency Representation:**

### ***Who is eligible***

Dependent of member, as defined by the EBF, who is charged as a juvenile delinquent.

### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal representation of the dependent in the juvenile delinquency proceeding.

**Benefit allowance**

Up to \$150.

**Limitations**

Only one juvenile delinquency proceeding per dependent per calendar year.

**Legal Defense Benefit In Other Civil Matters:****Who is eligible**

Member or dependent as defined by the EBF, who is resisting a claim which does not fall within any of the specified benefits and which is specifically excluded by other provisions of this plan.

**What is the benefit**

Reimbursement for attorney fees up to the EBF fee schedule allowance related to defense in a civil legal proceeding in which the member or dependent is a named defendant in an action brought before a court or administrative agency that involves him or her.

**Benefit allowance**

Without trial... Up to \$250.

With trial... Up to \$500.

Examples of this legal defense benefit would be costs of a lawsuit alleging breach of contract or a lawsuit concerning a garnishment. Such problems may be successfully resolved after consultation or it may require steps leading to actual representation and defense before an administrative agency.

This provision does not provide benefits for any Family Court proceedings or any civil proceedings which pertain to family or domestic relations matters. Any benefit for Family Court or such civil proceedings are exclusively within the provisions of the benefits entitled Domestic Relations Representation and Court Ordered Support.

**Legal Guardianship:****Who is eligible**

Member and/or spouse seeking legal guardianship of a person under the age 18 who permanently resides with the member and spouse or will permanently reside with the member and spouse if guardianship is granted or a child or legal ward of the member and/or spouse 18 years or older who is incapable of self-support by reason of mental or physical disability.

**What is the benefit**

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal representation in the guardianship proceeding.

**Benefit allowance**

Up to \$300 per guardianship proceeding.

**Limitations**

Maximum of one proceeding for each person of whom guardianship is sought.

**Personal Bankruptcy:****Who is eligible**

Member or spouse filing for personal bankruptcy.

**What is the benefit**

Reimbursement for attorney fees up to the EBF fee schedule allowance related to representation by an attorney in a personal bankruptcy proceeding.

**Benefit allowance**

Up to \$200.

**Limitations**

Limited to one personal bankruptcy per family per calendar year. Does not cover business bankruptcies.

**Personal Injury (Negligence) Matter:****Who is eligible**

Member or dependent as defined by the EBF.

**What is the benefit**

Reimbursement for attorney fees up to the EBF fee schedule allowance related to a payment for a type of legal proceeding in which there is customarily a contingent fee. Contingent fee matters are those in which a recovery of monies is attempted through a legal action, with an agreement with your attorney that fees are charged only if the action is successful.

Anyone who desires legal services in connection with the commencement of a claim for personal injuries suffered as a consequence of negligence can contact a law firm of their choice. However, legal counsel has a right to judge whether the case is worthy of prosecution before acceptance of your retention. For contingency fee matters, the only benefit payable under this plan is a \$20 consultation benefit if the attorney you consult is not retained and charges you a consultation fee.

**Benefit allowance**

Up to \$20.

**Principal Residence Mortgage Protection:****Who is eligible**

Member or spouse who is a defendant in a proceeding to foreclose a mortgage regarding a dwelling, condominium or cooperative, which the covered member and/or spouse owns and in which the member principally resides.



***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal advice and/or representation in the defense of a mortgage foreclosure involving any of the above stated residences.

***Benefit allowance***

Up to \$150 if the matter is resolved before trial. Up to \$300 should the matter proceed to trial.

***Limitations***

One foreclosure proceeding per calendar year per family and not exceeding a two family dwelling. Business property is not covered.

**Principal Residence Real Estate Closing:*****Who is eligible***

Member or spouse who is selling, purchasing or refinancing their principle residential dwelling, condominium or cooperative.

***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal representation for the sale, purchase or refinancing of property as described.

***Benefit allowance***

Up to \$300 per calendar year per sale, purchase or refinancing.

***Limitations***

Only one sale, one purchase and one refinancing per family in a calendar year is covered. This benefit provides representation with respect to one's personal residence (not to exceed a two family dwelling). Business property is not covered.

**Tenant Defense:*****Who is eligible***

Member or spouse who rents for personal residential use, a private dwelling, condominium, apartment or rooms as a tenant.

***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal advice and/or representation for a defendant in defense of a dispute between the member or spouse as tenant, and the landlord.

***Benefit allowance***

Up to \$150.

***Limitations***

Once the benefit is utilized, it may not be utilized again for one year.

## **Traffic Violation Representation:**

### ***Who is eligible***

Member or dependent as defined by the EBF, who is charged with a traffic violation.

### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal services during the defense of an alleged traffic violation. The violation charged must be of a serious nature that may affect the status of the defendant's driver's license.

### ***Benefit allowance***

Without trial... Up to \$150.

With trial... Up to \$300.

### ***Limitations***

Member or dependent must be the driver of the vehicle. Multiple allowances for violations charged on the same date are payable only if adjudicated on different dates.

## **Veteran and Servicemen's Rights:**

### ***Who is eligible***

Member or dependent as defined by the EBF, seeking remedial action in relation to denial of their veteran's rights by any military board or agency of the United States government.

### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to legal services for:

- a denial of veteran's benefits or rights.
- changes in type of military discharge.
- cases of court martial.
- connection with military boards convened for the purpose of imposing a penalty, an administrative discharge or a less than honorable discharge from military service.

### ***Benefit allowance***

Legal advice and counsel upon a denial of veteran's right for benefit... Up to \$100.

Legal representation to effect changes in types of military discharges... Up to \$250.

Legal representation in convened court martials or military boards... Up to \$500.

### ***Limitations***

Only the above stated matters that relate directly to member's or dependent's rights as a veteran are covered by the plan.

## **Wills and Living Trusts:**

### ***Who is eligible***

Member and their spouse.

### ***What is the benefit***

Reimbursement for attorney fees up to the EBF fee schedule allowance related to the preparation and execution of a Will or Living Trust, but not both.

### ***Benefit allowance***

\$70 per Will or Living Trust.

### ***Limitations***

Once the benefit is utilized, the member and spouse may not utilize this benefit again for five years.

## **EXCLUSIONS AND LIMITATIONS**

This Legal Services Plan provides benefits through allowances only as specifically stated and described herein. Legal services that have not been described are excluded from the plan. As a guide to employees in their utilization of the Legal Benefit Plan, the following list provides certain examples of the exclusions from the plan:

- Any benefit that is claimed after a period that exceeds one year from the calendar year in which legal services were rendered.
- Any proceeding or dispute or controversy with or against the employer or their agents or officers.
- Any proceeding, dispute or controversy directed against CSEA or any of its affiliated or parent entities, e.g. the Civil Service Employees Association, Inc. (CSEA), the CSEA Employee Benefit Fund (EBF) or any of the officers, agents or attorneys of these entities. This includes CSEA sponsored programs and the companies/organizations who administer them.
- Any proceeding, dispute or controversy where there is a prohibition against defraying the cost of such services by provision of law.
- Any business matter wherein as an officer, proprietor or shareholder, etc. a member or dependent is directly or indirectly involved.
- Matters that concern all federal, state and local income tax matters, including but not limited to preparation or filing of income tax returns.
- Any proceeding, action or controversy wherein two or more parties pool or combine benefits for the purpose of ascertaining a claim for their mutual benefit, e.g. class actions.
- Any Amicus Curiae activities.
- No benefits or allowances will be paid for services or advice when it involves a duplication of the same service or advice which was previously obtained in connection with the same problem.

- Any action, dispute, proceeding or controversy in which insurance will cover legal services or through which any government agency or attorney, such as Federal, State or Local provides legal services.
- Any matter for which legal services were obtained and completed before the employee became eligible to receive the benefit under this plan, regardless of when a bill for said services was rendered.
- The EBF will not pay or reimburse members, spouses, and/or dependents for court costs and/or filing fees, fines or penalties or interest.
- The EBF will not pay for more than one benefit if a member and spouse are eligible for a benefit and both claim payment for the same action.
- Members are reimbursed for legal expenses up to the lesser of the fees charged or the identified maximum for each service. It is important that you discuss with your attorney the estimated charges before you commence any legal work. Charges over the allowances are the responsibility of the member.
- If a court awards full or partial payment for legal fees, the EBF's reimbursement shall be reduced by the amount awarded. The total of the court award and the EBF's reimbursement will not exceed the amount charged by the attorney.
- Costs of document reproduction, filings, court fees, etc. are not covered nor are second opinion fees.
- If you are a covered employee at the time you retain counsel but are no longer on active payroll status at the time a legal matter is completed, you are not covered under this plan and the costs are your responsibility.
- Only matters specified in this brochure are covered.
- \$1,000 per calendar year (January 1-December 31) per family.
- The fund is not responsible for making initial payment to retain legal counsel.
- You cannot claim services if you represent yourself.

## **MATERNITY BENEFIT**

### **MAJOR PLAN FEATURES**

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- Covers eligible members.
- Upon the birth of a child, the Fund will pay \$200 to help cover the cost of maternity care.

### **WHAT IS THE BENEFIT**

- A member can receive the \$200 benefit if either the member or the member's wife/domestic partner has a child.

- Multiple births receive multiple benefits.
- This benefit is not diminished by any other medical benefit which may be received.
- Members who give birth while on maternity leave who would otherwise have been eligible for benefits if employment had been continued are still eligible for this benefit.

## HOW TO USE THIS BENEFIT

- Write or call the Fund Office to obtain a Maternity Benefit Claim Form:  
 CSEA Employee Benefit Fund  
 P.O. Box 516  
 Latham, New York 12110-0516  
**1-800-323-2732**  
 or download a form at [www.cseaebf.com](http://www.cseaebf.com)
- Submit your completed form with a copy of the child's birth certificate to the Fund Office.

## Exclusions and Limitations

- Members must have been eligible for Fund benefits at least nine months prior to the birth of the child.
- Members must be eligible on the date of the birth of the child.
- Adoption of a child is not covered under this benefit. Please see Adoption Benefit on page 18 under the Legal Plan for this service.
- Claims must be submitted by December 31st of the following year in which the child is born.

# UCS COMBINED CO-PAY REIMBURSEMENT BENEFIT

## MAJOR PLAN FEATURES

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- Reimburses prescription drug co-pays and co-pays from physician office visits. Reimbursement is processed once annually up to a maximum of \$325 per family per calendar year.

## WHAT IS THE BENEFIT

- Members are entitled to reimbursement once annually for physician office visit co-pays and prescription drug co-pays for themselves and their dependents.
- The claim can be made up of both types of co-pays mentioned above for a combined maximum reimbursement of \$325.
- Only one claim per calendar year is processed. To obtain the maximum benefit, wait until your co-pay expenses reach \$325 before filing your claim.

- If you do not accumulate \$325 before the end of the year, submit your claim after December 31st but before March 31st of the following year for what you did pay during the previous calendar year.
- Members must be eligible on the service date for the co-pay to be reimbursed.

## HOW TO USE THIS BENEFIT

- Write or call the Fund Office to obtain a UCS Combined co-pay Benefit Claim Form:  
CSEA Employee Benefit Fund  
P.O. Box 516  
Latham, New York 12110-0516  
**1-800-323-2732**  
or download the form at [www.cseaebf.com](http://www.cseaebf.com)
- Submit your completed form with your itemized pharmacy printout and/or health insurance EOBs when you have reached the maximum benefit allowed for the current calendar year. If you do not accumulate the maximum allowed, submit your claim after December 31 for what you did pay. **Deadline for submission of claims is March 31** of the following year.

**Prescription drug:** Only co-pays are reimbursed. Charges for non-covered drugs, items that cost less than your co-pay amount and brand/generic differentials are not reimbursed. Please submit an *itemized print-out* indicating dates of service, item dispensed and co-pay amount. Please do not use highlighter on print-outs.

**Physician office visit:** Only office visit co-pays are reimbursed. Only one (1) co-pay per visit is reimbursed. Co-pays for additional services performed at the same visit are not reimbursed. Non-physician provider, physical therapy, emergency room, hospital, urgent care. Lab, x-ray/imaging and dental co-pays are not eligible. Deductible/co-insurance payments are not eligible. Attach an Explanation of Benefits (EOB) from your health insurance carrier for each of the visits you are claiming.

**Cash register receipts, original pharmacy receipts/physician receipts and cancelled checks are not accepted for this benefit.**

## HEARING AID BENEFIT

### MAJOR PLAN FEATURES

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- Covers eligible employees and their dependents.
- Up to \$150 per ear once every three calendar years towards the cost of a hearing aid, including charges for its fitting upon the recommendation of a physician or otologist.

## HOW TO USE THIS BENEFIT

- Write or call the Fund Office to obtain a Hearing Aid Claim Form:  
CSEA Employee Benefit Fund  
P.O. Box 516  
Latham, New York 12110-0516  
**1-800-323-2732**
- Submit your completed form with your **paid bill** and a **copy of your doctor's prescription** to the Fund Office.
- The claim form will be subject to verification.
- The Fund will then send the **check to the member**.

### Exclusions and Limitations

- The Fund does not pay for:
  - any repairs to hearing aids
  - any non-durable equipment such as replacement batteries.
  - any appliances or expenses not recommended or approved by a physician or otologist.
- Claims must be submitted by December 31st of the following year in which the service was rendered.

## WORKPLACE SECURITY PLAN - Active Members Only

### MAJOR PLAN FEATURES

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- All public employees eligible for and enrolled in the CSEA Employee Benefit Fund are covered. Retired employees of the United Court System are not eligible for this benefit.
- The covered employee is insured for the trauma associated with an assault or hostage situation while performing his/her job duties.

### WHAT IS THE BENEFIT

- Criminal assaults while in pursuit of his/her occupational duties and resulting in at least 10 consecutive workdays absent from work immediately following the incident.

#### Benefit Payable:

*Level One* – Assault in the 1st Degree: \$10,000 for incidents involving injuries or fractures requiring a stay of 2 consecutive nights, or an incident of rape for the covered employee. There is no overnight stay required for rape.

*Level Two* – \$2,000 for assaults other than 1st Degree or fractures requiring a stay of 2 consecutive nights in the hospital for the covered employee.

*Level Three* – \$500 for all other incidents.

- Accidental death or dismemberment resulting from assault. A payment of \$10,000 per person per incident; 50 percent of sum for dismemberment of either hand or foot, or loss of sight in one eye.
- Permanent Total Disability resulting from assault. A one time payment of 400% of the assault benefit payable.
- Captivity while in the pursuit of his/her occupational duties. 0-8 hours – 25% of annual base salary of covered employee up to \$100,000 maximum. Eight hours or more – 50% of annual base salary of covered employee up to a maximum of \$100,000.
- Accidental death, dismemberment or permanent total disability during captivity while in the pursuit of his/her occupational duties. A payment of 100 percent of covered employee's annual base salary (not exceeding \$500,000); 50 percent of salary for dismemberment of either hand or foot, or sight in one eye.
- Accidental death due to occupation resulting from causes other than captivity or assault. A payment of \$1,000.

## **HOW TO FILE A CLAIM UNDER THIS BENEFIT**

- The Insured has the right to name a beneficiary. The beneficiary must be someone other than the Policy-holder. A Designation of Beneficiary form may be requested from Pearl Carroll & Associates LLC.
- Submit a completed Workplace Security claim form along with copies of the filed police report signed by the investigating officer which has been reported, in person, within 48 hours of incident, a medical statement certifying the extent of injuries and proof of immediate medical attention from the attending physician which has been sought within 24 hours of incident, and documentation from your employer indicating that you were performing your job duties at the time of injury and that the injury resulted in your being disabled from all job duties for a period of ten (10) or more consecutive work days to Pearl Carroll & Associates LLC, as soon as possible.

## **EXCLUSIONS AND LIMITATIONS**

- An assault will be deemed to have occurred when such action would be a violation of the state penal code dealing with assault and results in the insured being totally disabled from his/her usual occupation for a period of ten (10) consecutive working days or more immediately following the incident. This means ten (10) working days of absence from profession which must be authenticated by certification by a medical doctor, documented receipt of medical attention within twenty-four (24) hours of the event, and supportive



documentation of time missed.

- Evidence of assault to be a police report which has been filed in person within forty-eight (48) hours of incident, and physician's statement filed within twenty-four (24) hours of incident; captivity exists when an employee is held against his/her will and has been refused release.
- The Plan will use the *NYS Penal Law, Article 120* as the guideline for determining assault for all claims. The investigating officer's report must clearly indicate that a criminal assault has occurred.
- If any event is recoverable under more than one of the benefits listed above, benefits shall be payable under only one item of coverage, whichever is greater.
- The Plan will not pay benefits for any loss due to the following: suicide; attempted suicide; self inflicted injury; declared or undeclared war or any international armed conflict; injuries resulting from active duty of two months or more as a member in the armed forces.
- For Accidental Death & Dismemberment and Permanent Total Disability, loss must occur within twelve (12) months of the event in order to be payable. Permanent Total Disability means that the insured is unable to perform the substantial and material duties of his or her occupation for twelve consecutive months and a fully qualified medical practitioner certifies that the insured is beyond hope of improvement at the end of that twelve-month period.

**Designation of Beneficiary Forms and Workplace Security Claim Forms may be obtained from:**

**Pearl Carroll & Associates LLC  
12 Cornell Road  
Latham, NY 12110  
Attn: CSEA/EBF  
Workplace Security Claims  
Phone Toll Free - (800) 859-2552**

This description of coverage is only a summary of the benefits provided under the Workplace Security program underwritten by National Union. The provisions described are subject to the terms of Group Policy GTP-9064449.

Coverage will continue as long as the insured remains a public employee and receives one or more other benefits from the CSEA Employee Benefit Fund and the master policy remains in force.

## **CSEA EMPLOYEE BENEFIT FUND**

Danny Donohue, Chairman  
One Lear Jet Lane, Suite 1  
Latham, NY 12110-2395

**1-800-323-2732**  
**[www.cseaebf.com](http://www.cseaebf.com)**

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