WESTCHESTER COUNTY CORRECTION OFFICERS BENEVOLENT ASSOCIATION INC. WELFARE FUND BENEFITS BOOKLET

Dear Member: December 2018

On behalf of the Board of Trustees, I am pleased to provide you and your family with this updated Benefits Booklet, the third one published by the Westchester County Correction Officers' Benevolent Association Inc. Welfare Fund. This booklet represents the current plan of benefits ("Plan"). It describes the benefits that are provided to you and your eligible family members through the Welfare Fund.

We are committed to acquainting you with the benefits that you are entitled to and to making the process of obtaining these benefits as simple as possible. **Please read this booklet carefully to familiarize yourself with the benefits offered by the Welfare Fund.** It contains details about the benefits offered, applicable enrollment procedures, eligibility requirements, dependent coverage, and other helpful information. The Trustees are also committed to ensure that the Welfare Fund functions in a smooth and efficient manner.

This booklet describes the main features of the benefit programs offered through the Welfare Fund. The benefits provided may be changed by the Board of Trustees. All provisions of the Plan are subject to such rules and regulations as adopted or amended by the Trustees. If you have any questions about this booklet, or your benefits, please call the COBA Welfare Fund office at (914) 773-0436 or write us at COBA Welfare Fund, P.O. Box 231, Thornwood, NY 10594. Additionally, with respect to the dental and vision programs insured by **AMERITAS**, you may contact **AMERITAS** directly with any benefit or claim questions.

Sincerely,

David Summa
Board of Trustees, Chairperson

Trustees

Tonja Celestine	Neil Pellone	Jesus Quinones
Eileen Sacharewitz	Darryl Taylor	Alonzo West

Contact Information for Fund

Phone: (914) 773-0436
E-mail: cobawelfarefund@optimum.net
Address: P.O. Box 231, Thornwood, NY 10594

Contact Information for AMERITAS

Phone: 1-800-659-5556
Website: www.ameritas.com

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WESTCHESTER COUNTY CORRECTION OFFICERS INC. BENEVOLENT ASSOCIATION WELFARE FUND

Effective January 1, 2017

ELLIGIBILITY

You and your qualifying dependents are eligible for coverage in accordance with the rules and regulations of the Westchester County Correction Officers Benevolent Association Inc. Welfare Fund. Your coverage becomes effective the month following the date on which you complete four months of service. For example, if you start the academy on July 1 your coverage is effective December 1. Please note, as detailed in the following pages, certain dental services are limited to children (i.e., orthodontia) or are subject to a waiting period (i.e., major services, orthodontia). Proof of full-time student status (H.S. / College) must be supplied in writing for all dependents who are 19 years of age but have not yet turned 26.

All claims must be submitted within 90 days from the date of service.

The Trustees of the Fund reserve the right to review your and your dependent's eligibility to obtain Plan benefits. This includes the right to request proof and/or verification of such eligibility.

DEFINITIONS

A. MEMBER – The term "member" used in this booklet means an active correction officer or a correction officer who retired on September 1, 2000 or after.

B. PARTICIPANT – The term "Participant" means:

1. Any member who is eligible for benefits according to the provisions of the rules and regulations of the Westchester County Correction Officers Benevolent Association Inc. Welfare Fund.

2. The eligible member's lawful and current dependent spouse or dependent domestic partner registered with Westchester County. The Fund will require written proof of such dependence in advance of services (i.e., marriage certificate, domestic partner registration approval letter etc.)

3. The eligible member's dependent child defined as follows:

   (a) Unmarried child who has attained the age of three (3) years but has not attained the age of nineteen (19) years. In the event you have a child under the age of three (3) years who requires dental or vision services, please contact the Fund Office.

   (b) Unmarried child who is a high school student, or a full time student at an accredited institution of higher learning and has not attained the age of

twenty-six (26) years. Full-time student is defined as carrying at least twelve (12) college credits. Termination of coverage for a post-secondary student not returning to school is the last day of the month in which the student was enrolled in school.

(c) Unmarried child who is handicapped before the age of nineteen (19) years, and is dependent upon his parent or legal guardian for support.

Please note: The Welfare Fund will require written proof of a child's dependent status in advance of services (i.e., birth certificate, current letter from Registrar's Office confirming full time student status each semester, letter confirming handicap status from Social Security Administration, **AMERITAS** handicap status form etc.). **Please contact the Fund Office, prior to the start of services, for information on the type of documentation required.**

C. CHILD – The term "child" shall mean any child who is natural born, legally adopted or under the care of a legal guardian who belongs to the member or the member's eligible and current spouse or domestic partner (i.e., a step child).

D. DENTIST - The term "dentist" shall be deemed to mean a Doctor of Dental Surgery or Doctor of Medical Dentistry.

E. DENTAL/VISION SERVICE - The term "dental service" means any service listed in the Schedule of Covered Dental Services when performed by or under the direction of a licensed dentist. The term "vision service" means any service listed in the Schedule of Covered Vision Services when performed by or under the direction of a provider.

F. COVERED DENTAL/VISION EXPENSE – The term "covered dental expense" means the expense actually incurred for charges made by a dentist for the performance of a dental service when such service is essential for the necessary care of teeth. The term "covered vision expense" means the expense actually incurred for charges made by a vision provider for the performance of a vision service when such service is essential for the necessary care of eyes.

G. DENTAL/VISION PROVIDER – The term "Dental Provider" means the provider of dental services (i.e., your dentist). –The term "Vision Provider" means the provider of vision services (i.e., your optometrist).

H. OUT OF POCKET COST – Your expenses for medical care that are not covered or reimbursed by insurance or other plan.

SUSPENSION OF COVERAGE

In the event you, your spouse, domestic partner, or dependent make any false statements or engage in fraudulent conduct in connection with a claim for benefits, the Trustees reserve the right to suspend your eligibility under the Fund for all Plan benefits. Notwithstanding this, the Trustees reserve the right to enforce their legal rights to recoup improper benefit payments.

TERMINATION OF COVERAGE

Coverage will end on the day when the earliest of the following events occurs:

(1) Your employment ceases due to termination or resignation;

(2) You cease to be an eligible member, spouse, domestic partner or dependent;

(3) You stop making any payments required for your coverage; or

(4) The plan terminates.

In the event coverage is terminated as noted above, charges incurred for treatment that has not been completed will not be covered.

COORDINATION OF BENEFITS PROVISION – PART I

If you and your spouse or domestic partner both are or were member Plan participants (you are or were both COBA members) of this Plan, you are eligible for family coverage only through one participant (COBA member). An eligible child of two COBA members may be claimed as a dependent by only one participant (COBA member).

Please see additional Coordination of Benefits rules and guidelines on page 11.

DENTAL BENEFIT PROGRAM

ADMINISTRATION OF BENEFITS

The Dental Benefit Plan is fully insured through **AMERITAS** and covers the Calendar Year from January 1st - December 31st.

The Fund, through **AMERITAS**, offers a group of participating providers/dentists who accept this Plan and provide covered in-network dental services up to the allowable maximum benefit for each participant. **Please be sure to ask your provider/dentist whether he or she is a participating provider within the AMERITAS network and whether the treatment sought is fully covered under the Plan prior to treatment.** You may also obtain a list of participating providers or search for a provider close to you by zip code at www.ameritas.com.

DESCRIPTION OF PLAN BENEFITS

The benefits hereinafter set forth are payable, subject to the other provisions and limitations of the Plan, for "Covered Dental Services."

A. Amount of Benefits

The amount of benefits available to you for specific procedures will be in accordance with the schedule of fees adopted by **AMERITAS**.

Adults are not covered for orthodontic treatment; this is a benefit eligible only for a qualifying child. For the purposes of the orthodontic benefit a child is someone who has not attained the age of 19.

When an eligible participant has incurred covered dental charges for services, supplies or treatment furnished, services will be covered as follows:

	In Network	Out of Network
Preventative Services	100%	90%
Basic Services	100%	60%
Major Services	100%	40%
Orthodontic Services	50%	50%

B. Maximum Benefits

Benefits payable to each eligible participant and dependent is limited to **$2,250** in any one Plan year. (i.e. only $2,250 per person no exceptions). **Costs above this maximum are the participant's responsibility.**

The maximum life-time benefit for a child's **orthodontic treatment is $2,500. Costs above this maximum are the participant's responsibility.**

Your orthodontic treatments will be covered only for costs incurred prior to attaining the age of 19.

C. Waiting Periods

a. Participants are eligible for Preventative and Basic services once coverage begins the month following the date on which you complete four months of service. For example, if you start the academy on July 1 your coverage is effective December 1.

b. Participants are eligible for Major and Orthodontia services the month following the date on which you complete **one year of service.** For example, if you start the academy on July 1 your coverage is effective August 1 of the following year.

LIMITATIONS AND EXCLUSIONS

"Covered Dental Charges" shall in no event be deemed to include expenses incurred for the service, supplies or treatment:

A. Unless such services, supplies or treatment were prescribed as necessary by a dentist or physician.

B. In a Veteran's Administration Hospital, or which in the absence of coverage, would have been furnished without cost, or are furnished under conditions where the Covered Individual has no legal obligations to pay, or if the expenses are reimbursable by a local or other governmental agency, or

C. Covered under any group program or union, employer or association program to the extent that more than 100% recovery by the participant would be made for any charges for which benefits are provided hereunder.

D. If they were incurred on account of:

(1) war, declared or undeclared, including armed aggression;

(2) services, supplies or treatment received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group;

(3) loss or theft of dentures or bridgework;

(4) dentistry for cosmetic purposes, exclusive of orthodontia, including alteration or extraction and replacement of sound teeth for the purpose of changing appearance;

(5) bodily injury arising out of and in the course of employment by any employer, or disease or defect with respect to which benefits are payable under any Workmen's Compensation or Occupational Disease Act or Law.

E. Crowning of teeth for periodontal support is not covered.

F. Temporary services are not covered expenses (except interim dentures).

SUBMISSION OF PRE-TREATMENT ESTIMATES

We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insurance provider (**AMERITAS**).

A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

COVERED DENTAL SERVICES

The following is a sample listing of covered services. For further information please contact **the AMERITAS Claims Department at 1-800-659-5556.**

In Network and Out of Network

Type 1

- Routine Exam
  (2 per benefit period)
- Bitewing X-rays
  (2 per benefit period)
- Full Mouth/Panoramic X-rays
  (1 in 3 years)
- Cleaning
  (4 per benefit period)
- Fluoride for Children 18 and under
  (2 per benefit period)
- Pre-Diagnostic Test (age 35 and over)
  (1 in 2 years)

Type 2

- Periapical X-rays
- Sealants (age 18 and under)
- Space Maintainers
- Restorative Amalgams
- Restorative Composites

Type 3

- Onlays
- Crowns Sample Procedure Listing (Current Dental Terminology © American Dental Association.)
- In Network and Out of Network
- Type 1 Type 2 Type 3
- Routine Exam
- (2 per benefit period)
- Bitewing X-rays
- (2 per benefit period)
- Full Mouth/Panoramic X-rays
- (1 in 3 years)
- Cleaning
- (4 per benefit period)
- Fluoride for Children 18 and under
- (2 per benefit period)
- Pre-Diagnostic Test (age 35 and over)
- (1 in 2 years) Periapical X-rays
- Sealants (age 18 and under)
- Space Maintainers
- Restorative Amalgams
- Restorative Composites Onlays
- Crowns
- (1 in 5 years per tooth)
- Crown Repair
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Denture Repair
- Implants
- Prosthodontics (fixed bridge; removable complete/partial dentures)
- (1 in 5 years)
- Simple Extractions
- Complex Extractions
- Anesthesia
- (1 in 5 years per tooth)
- Crown Repair
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Denture Repair
- Implants
- Prosthodontics (fixed bridge; removable complete/partial dentures)
  (1 in 5 years)
- Simple Extractions
- Complex Extractions
- Anesthesia

HOW TO FILE A CLAIM **(If Dentist is out-of-network and not an AMERITAS participating provider.)**

Step 1 - Request an **AMERITAS** dental claim form from the Fund Trustees, COBA office or COBA website at www.westchestercoba.org.

Step 2 - Complete the form in full (if all questions are not answered the form may be returned and will delay benefit payment).

Step 3 - Have your Dentist complete the provider portion and then submit the claim form to **AMERITAS** at the address on the claim form.

Step 4 Send all claims within 90 days from the date of service.

COMMON CLAIM PROBLEMS

A. Incomplete information regarding whether you or your spouse has other group insurance coverage, and if so, name or group, name of insurance company, address, policy number, etc.

If there is other group coverage, send a copy of the benefit payment record furnished by the other plan.

B. Incomplete information regarding dates of birth or age.

VISION BENEFIT PROGRAM

ADMINISTRATION OF BENEFITS

The Vision Benefit Plan is fully insured through **AMERITAS**. The Plan Year for vision benefits runs for the twelve months from the date of service. For example, if you have an eye exam or receive glasses on September 1, you are not eligible for another exam or glasses until September 1 of the following year.

PARTICIPATING PROVIDER VISION PROGRAM

The Plan offers the services of certain participating providers. By using one of these providers you and your eligible dependents will be able to receive a vision examination and glasses with no out-of-pocket expense provided you stay within the fee schedule.

The program offers a selection of frames and lenses from which you may choose. If you decide **not** to use frames or lenses offered through the program, **you will have to pay the provider's charge for the frames and lenses you choose.**

Please contact the Welfare Fund for a list of participating providers. When using a participating provider, please identify yourself as having vision coverage through Westchester COBA, with **AMERITAS** as Plan Administrator.

NON-PARTICIPATING PROVIDER VISION PROGRAM

If you use a provider who is not a participating vision program provider, the Plan will provide reimbursement in accordance with the allotments found in the fee schedule.

FEE SCHEDULE

The applicable Fee Schedule for covered services is as follows:

Exam:	$ 55
Frames:	$ 60
Lenses:	
Single Vision Lenses:	$ 60
Bifocals:	$ 80
Trifocals:	$ 95
Lenticular:	$100
Progressives:	$100
Contacts:	$120

COVERED VISION SERVICES

EXAMINATIONS & GLASSES

The Plan will allow a maximum benefit per individual to be used for an eye examination and glasses (frames & lenses) or contacts.

The Plan will only pay amounts up to the benefit allotment as specified in the fee schedule and is not responsible for charges in excess of the benefit allowance. Eye examinations, glasses (frames & lenses), and contacts are covered once a year from your last date of service. The Plan will pay for glasses or contacts but not both. **Sunglasses are not covered by this plan**.

If you use an ophthalmologist for an eye examination, services are covered through your medical plan (i.e. POMCO). You are responsible for any applicable medical co-payments. You may then use a participating or non-participating provider to purchase your frames, lenses etc. through the Plan.

FILING CLAIMS

If you use a participating provider, your provider will file the required claim forms.

If you use a non-participating provider, you will need to file a claim form with **AMERITAS** for reimbursement in accordance with the fee schedule. Your submission must include a detailed account of the service used and proof of payment. You may obtain a claim form from the Fund trustees, the COBA office or COBA website at www.westchestercoba.org.

ADDITIONAL BENEFITS OFFERED THROUGH THE FUND

LASIK SURGERY PROGRAM

The Welfare Fund allows a $500.00 per eye reimbursement benefit for any out of pocket costs incurred for Lasik surgery. **If you use this benefit you will not be eligible for vision benefits for five years.** If after Lasik surgery vision benefits are a medical necessity, you may submit an appeal for reinstatement of vision benefits to the Trustees. **This is a member only benefit.**

You may obtain a reimbursement form from the Fund Trustees, COBA office or the COBA website at www.westchestercoba.org.

HEARING BENEFIT PROGRAM

The Welfare Fund offers a $250 per ear reimbursement benefit for any out of pocket costs incurred for hearing aids **once in a five year period. This is a member only benefit.**

You may obtain a reimbursement form from the Fund Trustees, COBA office or the COBA website at www.westchestercoba.org.

LIFE INSURANCE

Active Member

The Welfare Fund provides a term life insurance benefit to your designated beneficiary in the event of an active member's death. The current life insurance benefit is one hundred thousand dollars ($100,000)

Retiree Member

The Welfare Fund provides a term life insurance benefit to your designated beneficiary in the event of a qualifying retiree member's death. A qualifying retiree is an officer who retired on or after January 1, 2016. This benefit begins on the date of his or her separation from the County and the policy will be in effect for ten (10) years from the separation date. For qualifying retirees who retired between January 1, 2016 and through and including December 2018, the start date of the term policy will be January 1, 2019, and will expire ten (10) years from then which is December 31, 2028. The current life insurance benefit is fifteen thousand dollars ($15,000).

Please be reminded, for all life insurance policies, it is your responsibility to keep your beneficiary designation current. You may obtain a form to change beneficiaries from the COBA office.

SHORT - TERM DISABILITY PROGRAM

The Welfare Fund offers a short term disability program. In the event an active member is disabled and unable to perform his/her normal workday activities, a $500 weekly disability benefit will be available for a maximum of six weeks. The following parameters will be in effect:

1) An active member must first exhaust all leave time (i.e. vacation, sick, holiday, half-pay, supplemental, personal), and not be receiving the following: social security disability, workers' compensation or GML 207-c benefits, and any other form of salary, income, disability payment or insurance benefits before becoming eligible for this benefit.

2) An active member must submit the required claim form providing sufficient details as to need. You may obtain a claim form from the Fund Trustees, COBA office or the COBA website at www.westchestercoba.org.

3) An active member is eligible for this benefit **for an original illness or injury**, and **not for any aggravation or reoccurrence** of a particular illness or injury.

4) An active member is eligible for this benefit **only once**.

5) All claims must be submitted no more then **(1) year** after you come off the payroll.

CO-PAY REIMBURSEMENT PROGRAM

At the discretion of the Trustees, the Welfare Fund may offer a co-pay reimbursement for the member, spouse/domestic partner, or dependent child, during a Plan year up to a specific amount. Reimbursement applies only to co-payments for doctor/ER visits and prescription drugs. Valid proof of payment, as determined by the Trustees, must be provided in order to be reimbursed.

The current benefit amount is $300 which, as with all Plan provisions, is subject to change.

COBRA - EXTENSION OF BENEFITS

Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) certain individuals are given the option of continuing their health insurance benefits, including dental and vision coverage under specified conditions.

You and your dependents are eligible to continue insurance for up to 18 months when termination of insurance is due to a reduction in your hours worked, or upon termination of your employment.

Amendments to COBRA stipulate that a member who (a) elects continuation coverage as the result of termination of employment and (b) is subsequently determined by Social Security to have been disabled as of the date of termination is entitled to continue coverage for 29 months instead of 18 months.

Your dependents are eligible to continue their insurance for up to 36 months upon the occurrence of the following events.

(a) The spouse and children upon the death of the covered employee.

(b) The spouse, upon divorce or legal separation from the employee.

(c) The spouse and children of Medicare-eligible employees, when the employee ceases to participate in the employer-sponsored plan.

(d) Dependent children when they cease to be a dependent child under the definition in the policy.

The insurance cannot be continued beyond any of the following dates.

(a) The date on which the employer ceases to provide any group health plan to any employee. If a group health insurance policy ceases to be in force with regard to

employees of the employer, it would be your employer's obligation to allow you or your dependent(s) to continue coverage under any replacing group policy or policies.

(b) The date the premium is not paid by the individual.

(c) When the individual becomes covered by any other group health plan or when the individual is entitled to Medicare benefits.

(d) In the case of a spouse, when the spouse remarries and becomes covered under another group health plan.

If your insurance terminates, or is about to terminate, you will be provided with a Continuation of Coverage Election Form which will enable you and your spouse to elect or reject continuation of group health coverage. You are responsible for providing us with current information as to your family status (i.e. separation, divorce, or dependent ineligibility for coverage.)

Your election to continue coverage must be completed within 60 days after you receive this Continuation of Coverage Election Form, or your termination date, whichever occurs last. Benefits provided shall be identical to coverage provided for active full-time employees and their dependents who have insurance under the plan but have not yet terminated their coverage. **The cost to continue coverage is paid for by the individual.**

For a complete description of COBRA and questions regarding your right to continue insurance after your termination date, please contact your Trustees or Plan Administrator.

COORDINATION OF BENEFITS PROVISION - PART II

Some individuals have coverage in addition to the benefits provided by this plan. Except as stated elsewhere, when this happens, the amount of benefits payable under this plan will take into account any coverage a Participant has under "other plans" so the combined benefits under this Plan and the "other plans" will not exceed the total expenses involved.

For purposes of coordinating benefits of multiple coverage, an "other plan" means any plan of dental coverage provided by:

A. group insurance or any other arrangement of coverage for individuals in a group which provides dental benefits or vision services on an insured or an uninsured basis;

B. "no fault" automobile insurance which is required under any law and is provided on other than group basis; or

C. plans provided by the U.S. Government, State Government or any instrumentality's thereof.

In coordinating the benefits for a Participant having multiple coverage, the "primary" plan pays first and the "secondary" plan pays next to make up the difference, but the total benefit paid by both the primary and the secondary plans will not exceed 100% of the allowable expenses incurred. In addition, no plan will pay more benefits than it would normally provide without this special

coordinating provision. In determining which plan is primary and which plan is secondary, the following order will be used:

A. A plan without a coordination of benefits provision will always be the primary plan; and

B. If all plans have a coordination of benefits provision then:

(1) The plan covering the Participant as an Employee is primary;
(2) The plan covering the Participant as a Dependent Spouse is secondary.
(3) With respect to Dependent Children, the plan that covers a person as a dependent of an employee whose month and day of birth occur earlier in the calendar year will be considered primary.

****** WHEN SUBMITTING CLAIMS FOR MEMBERS OF THE FAMILY WHO ARE PRIMARY THROUGH ANOTHER CARRIER AND SECONDARY TO THE PARTICIANT'S PLAN, A COPY OF THE PRIMARY PLAN'S PAYMENT MUST ACCOMPANY THE CLAIM**

APPEALS

A. Dental and Vision Benefit Appeals

You and your eligible dependent may have the ability to grieve and/or appeal a denial of coverage. This process is administered by **AMERITAS**. Please note, what you can appeal and the time frame in which you must file your appeal varies. Please contact **AMERITAS** at 877-897-4328 to find out more information.

B. Other Benefit Appeals

Appeals of benefit denials other than dental and vision must be filed in writing with the Welfare Fund in a timely fashion. Please also include any documentation and/or proof supporting your appeal.

RIGHT OF RECOVERY

A. Whenever we have made payments for Covered Services in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, irrespective of to whom paid, we have the right to recover the excess payment from one or more of the following: any person to or for whom such payments were made, any insurance companies or any other organization.

B. You, personally and on behalf of your enrolled dependent will, upon request, execute and deliver such documents as may be required and to recover excess payments. Your failure to comply will result in a withdrawal of benefits already provided or a denial of benefits requested.

COMMON QUESTIONS

Q. Who is covered?
A. You and your eligible dependents.

Q. Who is **AMERITAS**?
A. Your plan administrator for dental and vision.

Q. What is COBRA?
A. A federal regulation which allows you to continue coverage after you have lost it. Coverage can continue for up to 18 months at a monthly premium which you are required to pay.

Q. Who is an eligible dependent child?
A. Any child through age 18; or from age 19 until age 26 if a full-time student.

Q. What happens if there is a change in my family status?
A. Report these changes immediately to the Welfare Fund office.

Q. What can I do if a questionable claim is denied for Dental?
A. You can send a letter of appeal to **AMERITAS**. See pg 6 for contact information.

Q. Should I use a participating provider for dental and vision benefits?
A. Yes, to keep out of pocket costs to a minimum.

Q. Are contact lenses covered?
A. Yes, in lieu of glasses.

Q. When does eligibility begin?
A. Your are eligible for benefits the month following the date on which you complete four months of service. Certain dental benefits are subject to waiting periods.

Q. Upon separation from service (retirement, resign, terminated, etc.), what do I do?
A. Contact the COBA office for further information or speak to a Trustee.