May 1, 2025

SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION
WELFARE FUND

1363-24 Veterans Memorial Highway
Hauppauge, NY 11788
(631) 231-3983 • FAX: (631) 231-3986

ACTIVE MEMBER PLAN OF BENEFITS

May 1, 2025

This booklet contains very important information concerning the excellent benefits you enjoy as an active employee represented by the Suffolk County Court Employees Association, Inc.

All of the benefits under this Active Member Plan of Benefits (the "Plan") offered by the Suffolk County Court Employees Association Welfare Fund (the "Fund") are self-administered, and the Fund contribution levels are established through collective bargaining.

The Trustees have worked consistently to maintain the benefits on a regular basis. We hope to continue to provide our members with these benefits and to continue Plan improvements whenever possible. Understand that the Trustees of the Fund reserve the right to amend, modify and/or terminate the benefits offered by this Plan, should conditions so warrant.

If you have any questions regarding your benefits under the Plan, please contact the Fund office at (631) 231-3983.

John Tufarella,
Chairman

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SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND

Active Member Plan of Benefits

I. GENERAL INFORMATION

A. ENROLLMENT

Coverage for the benefits offered by the Suffolk County Court Employees Association Welfare Fund (the "Fund") under this Active Member Plan of Benefits (the "Plan") is not automatic. *In order to participate, eligible members must first enroll themselves and their eligible dependents in the Fund by completing and forwarding enrollment cards to the Fund Office.* Enrollment cards can be obtained by calling the Fund Office at (631) 231-3983.

All participants must provide the Fund with their current address, and must provide adequate notice of any changes in their home address and/or contact information.

B. ELIGIBILITY FOR BENEFITS

The following are eligible ***participants*** in the Plan:

1. A full-time employee covered by the collective bargaining agreement between the SCCEA and the State of New York-Unified Court System, and for whom contributions are made to the Fund on their behalf. As used in this section, a full-time employee is defined as an employee who is in full pay status and whose normal work schedule consists of at least 70 hours per bi-weekly pay period. A full-time employee who is on authorized leave pursuant to the Family and Medical Leave Act, and a full-time employee who is absent on Workers' Compensation leave for whom the Fund is receiving contributions, shall be entitled to a continuation of benefits while on such leave. A full-time employee receiving sick leave at half pay that is not on authorized leave pursuant to the Family and Medical Leave Act shall be considered an eligible part-time employee.

2. A part-time employee covered by the collective bargaining agreement between the SCCEA and the State of New York-Unified Court System, and for whom contributions are made to the Fund on their behalf. As used in

this section, a part-time employee is defined as an employee who is in full-pay status and whose normal work schedule consists of at least 35 hours per bi-weekly pay period. A part-time employee who is on authorized leave pursuant to the Family and Medical Leave Act, and an employee who is absent on Workers' Compensation leave for whom the Fund is receiving contributions, shall be entitled to a continuation of benefits while on such leave.

The following are eligible ***dependents*** in the Plan:

1. The spouse of a Plan participant, provided he or she is not legally separated from the participant.

2. The child of a Plan participant, ending the month in which the child turns age 26.

3. A domestic partner of a Plan participant. To qualify, the domestic partnership must be registered in the office of the county clerk in any county in New York State or in any similar registry in another jurisdiction.

4. An unmarried child or grandchild of a Plan participant, who permanently lives with the participant and is supported by him or her pursuant to a court order awarding legal guardianship, provided that guardianship commenced before the child attained age 26.

5. An unmarried child of an eligible employee who is incapable of self-support, regardless of age, by reason of mental or physical disability and who became so disabled before reaching age 26.

6. Coverage may be extended past the age of 26 for an unmarried child who is a full-time student, had four (4) years of service in a branch of the U.S. Military between the ages of 19 and 25 and is not eligible for other employer group health coverage. Up to four (4) years of military service may be deducted for the child's age until the adjusted eligibility age equals 26.

C. WHEN ELIGIBILITY BEGINS

1. Except as provided in paragraph 3 below, eligibility for participants commences upon completion of sixty (60) days of full-time or part-time service in a position within the SCCEA bargaining unit, provided that necessary enrollment cards are completed and filed at the Fund Office. If the required enrollment card is not submitted by the time a participant completes sixty (60) days of full-time service, eligibility will commence on the first (1st) day of the month following receipt of the enrollment card by

the Fund office.

2. Dependents become eligible at the same time that the participant does.

3. Eligibility for employees who (i) transfer or promote into the SCCEA bargaining unit from other collective bargaining units in the Unified Court System; and/or (ii) were previously unrepresented employees of the Unified Court System assigned to Suffolk County and who are placed in the SCCEA bargaining unit, shall commence upon the first (1st) day of assignment within the SCCEA bargaining unit, provided that necessary enrollment cards are completed and filed with the Fund Office. If the required enrollment card is not submitted on or before the first (1st) day, eligibility shall commence on the day that the enrollment card is received by the Fund office. This paragraph shall not apply to the Life Insurance benefit. (*See* Life Insurance Section).

4. No benefits shall be payable for any services performed prior to the date that an individual becomes an eligible Plan participant/dependent.

D. SPECIAL ENROLLMENT RIGHTS

Participants who decline to enroll themselves or their dependents because of other health insurance or group health plan coverage, may be able to enroll themselves and/or their dependents in this Plan if the participants and/or their dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, participants must request enrollment within sixty-one (61) days after the other coverage ends for themselves and/or their dependents (or after the employer stops contributing toward the other coverage).

In addition, when a participant has a new dependent-spouse as a result of marriage, or a new dependent-child by virtue of a birth, adoption, or placement for adoption, they may be able to enroll themselves and their eligible dependents. However, participants must request enrollment within sixty-one (61) days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, participants should contact the Fund Office at (631) 231-3983.

E. FILING OF CLAIMS

1. All claims for Fund benefits under this Plan must be submitted on appropriate claim forms. Claim forms can be obtained by calling the Fund Office at (631) 231-3983, or online at www.sccea.org. Claim forms may also be available at personnel offices. All claims must be accompanied by any information or proof requested by the Fund Office which is reasonably required to process the claim.

2. Deadlines for Filing Claims:

Plan Benefit	Deadline
• Dental (direct reimbursement) • Optical (direct reimbursement) • Hearing Aid • Health Expense Reimbursement • Heart, Lung, and Body Scan	No later than December 31st of the calendar year in which the claim was incurred.
Long-Term Disability Benefit	No later than twelve (12) months of the first (1st) day of the commencement of the total disability, or knowledge thereof, subject to determination of the Fund Trustees.
Life Insurance	Claim deadline is contained in the Life Insurance Policy certificate.

3. Participating Providers:

While the Trustees in no way endorse the use of Participating Providers, members may choose a Participating Provider who has agreed to provide specific benefits within the reimbursement allowances provided by the Fund for Dental, Optical, and Hearing Aid benefits. Participants are responsible for all charges for non-covered services. A list of providers and reimbursement allowances for Dental, Optical, and Hearing Aid benefits can be obtained from the Fund Office Monday through Friday, (631) 231-3983, or online at www.asonet.com.

In the event that a participant/dependent uses any of the Fund's Participating Providers for Dental, Optical, and/or Hearing Aid benefits, claims may be submitted to the Fund directly by the Participating Provider.

F. TERMINATION OF BENEFITS

Benefits for participants cease at the end of the calendar month in which they cease to meet the Plan's participant eligibility requirements. Benefits cease for dependents at the time that benefits cease for the participant, or when the dependent ceases to meet the Plan's dependent eligibility requirements, whichever first occurs.

G. COORDINATION OF BENEFITS

Coordination of benefits provides that each Fund benefit is coordinated with any other plan under which an individual is covered so that the total benefits available will not exceed 100% of the reasonable and customary charges or the actual charges, whichever is less. The plan covering the participant directly is the primary plan. If a dependent-child is covered under another plan, the plan of the parent whose birthday comes first in the calendar year is the primary plan; however, if the parents are divorced or legally separated, except as provided by a Qualified Medical Child Support Order (QMCSO) court order, the plan of the parent with custody pays benefits first.

All Fund benefits available under this Plan must be coordinated with any other plan which provides coverage. Where both spouses are eligible Plan participants, their dependent-children will be covered to a maximum of the normal, reasonable and customary charges or the actual charges, whichever is less, available through the combined coverage of both spouses. The claims of both spouses must be submitted together.

With respect to Life Insurance benefits, a person may not have coverage both as a participant and as a dependent. If both spouses are full-time participants, only one eligible spouse may cover the dependent-children as insured dependents.

H. PAYMENT

The procedures for payment of benefits vary. Payments are made either to the participant directly or to the provider for the particular service. Payments are made in accordance with the level of benefits provided in this Plan, and the Fund is not responsible for any amounts due in excess of Plan provisions.

I. CHANGES IN THE PLAN

The Trustees may amend, change, delete or modify benefits as well as the rules, regulations and procedures of the Plan.

II. PLAN BENEFITS

DENTAL BENEFIT

A. Who is Eligible

Full-time participants and their eligible dependents.

Part-time participants and their eligible dependents.

B. Benefit Defined

1. Non-Orthodontic

There is a $2,500.00 annual per person maximum for non-orthodontic services in a calendar year. Payment will be made for non-orthodontic dental services up to the amount provided under the Schedule of Covered Dental Expenses. This Schedule is contained in a separate pamphlet. In the case of pediatric dentistry, treatments shall be paid per Schedule.

2. Orthodontic

There is a separate benefit for orthodontic services with a lifetime per person maximum of $1,995.00. Pediatric orthodontic treatments shall be paid per Schedule.

C. Pretreatment Review

The Pretreatment Review Program is designed to give participants/dependents and dentists a better understanding of the Schedule of Covered Dental Expenses payable under the Plan before services are provided. Dentists should submit a pretreatment review claim form for crowns, bridges, dentures or when services are expected to exceed $300.00. The Fund will then determine the benefits which will be payable for each dental service and return the approved claim to the dentist.

If this Pretreatment Review Program is not followed, payment will be determined by taking into account alternate procedures or services, based on acceptable standards of dental practice.

D. Dental Emergencies

If a participant/dependent has a dental emergency for which a

Participating Provider is not reasonably available and the participant/dependent uses a non-Participating Provider, the Trustees may authorize the Fund to reimburse an amount not to exceed the amount which the Fund would have paid to a Participating Provider who performed the same services under the Plan.

HEARING AID BENEFIT

A. Who is Eligible

Full-time participants and their eligible dependents.

B. Benefit Defined

1. The Fund will pay one (1) claim every four (4) calendar years towards the cost of a hearing aid, up to a maximum of $525.00 per person, commencing with the first year of service. Covered expenses are limited to charges for the cost and installation of a hearing aid as prescribed by an Otologist, Audiologist or Physician.

2. The Fund will pay one (1) claim every four (4) calendar years for the repair of a hearing aid, up to a maximum of $75.00 per person.

3. These benefits are non-cumulative.

C. Exclusions

1. Expenses for which benefits are payable under Workers' Compensation Law.

2. Expenses for which benefits are payable under Medicare or other Government plan.

3. Special procedure training, such as lip reading courses, schooling or institutional services.

4. Medical or surgical treatment of the ear or ears.

D. Coordination of Benefits

This benefit must be coordinated with any health insurance or other plan which provides coverage for hearing aids, and proof of such coordination (EOB) from primary insurer showing out-of-pocket expense must be submitted with the claim.

OPTICAL BENEFIT

A. Who Is Eligible

Full-time participants and their eligible dependents.

B. Benefit Defined

The Fund will reimburse each eligible participant/dependent for optical services obtained from any licensed optometrist, ophthalmologist or optician up to an annual maximum of $150.00 per person. Reimbursement for all claims shall be based on a one-time payment per person in any calendar year.

HEALTH EXPENSE REIMBURSEMENT BENEFIT

A. Who is Eligible

Full-time and part-time participants.

B. Benefit Defined

The Fund will reimburse full-time participants up to an annual maximum of $300.00 per calendar year effective for calendar year starting January 1, 2024 ($200.00 per calendar year for prior years), and part-time participants up to an annual maximum of $100.00 per calendar year, for the following expenses that they incur:

1. Health insurance premium contributions made towards NYSHIP or any other New York State issued health plan applicable to court employees. Payment is limited to such health insurance premium contributions required to be made by the participant. In order to be reimbursed for this expense, eligible participants must provide the Fund office with supporting documentation such as a record of their salary payment.

2. Prescription drug costs and health insurance co-payments.

C. Claim Filing Requirements

Claims can be submitted at any time until the maximum is met, but not later than December 31st of the year in which eligible health expense was incurred.

To receive reimbursement of eligible health expenses, participants must complete the appropriate claim form and send it to the Fund Office along with all supporting original documentation (Explanation of Benefits (EOB)) or other proof that will verify the claim. No reimbursement will be made without, at a minimum, (1) a written statement of an independent third-party such as an EOB stating that the expense had been incurred and the amount of the expense; and (2) a written statement and documentation (e.g., pharmacy receipts or printouts with relevant information) from the participant that the expense has not been reimbursed and is not reimbursable under another health plan coverage. **No reimbursement of eligible health expenses under this benefit provision shall be made if such expenses have been reimbursed by any other health care insurance, provider or entity.**

LIFE INSURANCE

A. Who Is Eligible

Full-time participants and their eligible dependents. Dependent-children of full-time participants are eligible up to 18 years old, unless they are a full-time student, in which case they are eligible up to 23 years old.

Part-time participants and their eligible dependents. Dependent-children of part-time participants are eligible up to 18 years old, unless they are a full-time student, in which case they are eligible up to 23 years old.

A person may not have coverage both as a participant and as a dependent. If both spouses are full-time participants, only one eligible spouse may cover the dependent-children as insured dependents.

B. Benefit Defined

1. The Fund will provide a Life Insurance policy for eligible full-time participants and their dependents according to the schedule outlined in the insurance certificate. Full details of all provisions are contained in the certificate issued by the insurance carrier.

2. Full-time participant coverage is $50,000 with an additional payment of $50,000 for accidental death and dismemberment.

3. Part-time participant coverage is $25,000 with an additional payment of $25,000 for accidental death and dismemberment.

4. Dependent coverage is $10,000 for full-time participants.

5. Dependent coverage is $5,000 for part-time participants.

C. Claim Filing Requirements

The designated Life Insurance beneficiary must provide the Fund with written notice of claim and proof of life insurance per the terms of the insurance policy with the Fund.

LONG TERM DISABILITY BENEFIT

A. Who Is Eligible

Full-time participants only.

B. Defined Benefit

After an eligible participant has been totally disabled for six (6) continuous months as a result of a non-occupational injury or disability, the Fund will provide monthly payment of $400.00 (subject to withholding taxes) while the participant is totally disabled and prevented from working. In order to be eligible for the benefit, a participant must be in full-time status at the time that the employee became totally disabled. Benefit payments may continue for a period of up to two (2) years, after the six (6) month waiting period, subject to the following: during the initial six (6) month waiting period and the first year of disability benefits, an eligible participant is considered totally disabled if they are unable to perform the work of their occupation/job position; after the first year of disability benefit payments, an eligible participant is not considered totally disabled unless they are unable to work in any employment or occupation. This benefit shall terminate if and when an otherwise eligible participant receives retirement benefits from the New York State Employees Retirement System.

C. Limitations

No benefits are payable for:

1. Any injury or illness that is job-related for which the participant is covered by Workers' Compensation;

2. Any injury or illness due to war or an act of war;

3. Any injury or illness which is covered by no-fault automobile insurance;

4. Any injury or illness commencing while the participant was on active, reserve, or National Guard duty in the military;

5. Any mental illness or functional nervous disorder;

6. Any disability caused by intentionally self-inflicted injuries unless such self-inflicted injury was caused as a result of a diagnosed underlying medical condition; and

7. Any disability resulting from drug or alcohol abuse.

HEART, LUNG AND BODY SCAN BENEFIT

A. Who Is Eligible

Full-time participants and retirees only who are between the ages of 40 and 70.

B. Benefit Defined (One Time Benefit)

The Fund will provide a one-time, maximum reimbursement of $200.00 per lifetime for one heart, lung or body scan by a provider arranged by the Fund. This benefit shall not apply to scans which are covered by insurance.

III. CLAIM REVIEW PROCEDURE

1. Notice of any decision by the Fund Trustees to deny a claim for benefits under this Plan must be provided within sixty (60) days of the Fund's receipt of the claim. If the Fund is unable to make a decision within that time due to circumstances beyond the Fund's control (such as late receipt of medical records), it must notify the participant/dependent before expiration of the original sixty (60) days that it intends to extend the time, and then may take as long as thirty (30) additional days to reach a decision. If the Fund Trustees need the 30-day extension because the participant/dependent did not provide all of the information needed to process their claim, the Fund will identify what information is missing.

2. If an individual's claim is incomplete, they must provide the Fund with the additional information by no later than forty-five (45) days from the date

that the notification was mailed by the Fund regarding the incomplete claim. If an individual fails to send the Fund the missing information within this 45-day period, the Fund will deny the claim.

3. If, for any reason, a benefit claim is denied, a Notice of Initial Claim Denial will be provided by the Fund. The manner and content of this notice will include the following:

a. The specific reasons for the denial;

b. Reference to the specific Plan provision being relied on;

c. Any additional information that is required to complete the claim and an explanation as to why the information is required; and

d. A description of the Plan's review procedures and time limits.

4. An individual who has received a notice that their benefit claim has been denied may request a review of the denied claim within one hundred and eighty (180) days of the receipt of the notice of denial. Participants/dependents will have reasonable access to and copies of, upon request and free of charge, all documents, records and other relevant information related to the claim. The review will take into account everything submitted by the individual (whether submitted in the original claim or not).

5. Requests for a review of a claim must be made in writing and sent to the Fund Office, which will act as follows with respect to the claimant's transmittal:

a. Send a copy to the insurance organization if an insured benefit is involved, or

b. Bring it to the attention of the Board of Trustees in the case of benefits provided directly by the Fund on a self-insured basis.

6. If the request for review involves a claim for benefits that are provided directly by the Fund on a self-insured basis, the Board of Trustees will render a decision within sixty (60) days after the receipt of the request for the review, unless special circumstances require an extension of time, in which case a decision will be rendered within ninety (90) days. The decision of the Board of Trustees will be in writing. The Trustees shall have exclusive authority and discretion, among other things, to interpret the provisions of the Trust Agreement and of the Plan.

IV. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled "alternate payees". Both participants and their dependents can obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Administrator.

Upon receipt of a Qualified Medical Child Support Order, the Fund Administrator will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a participant under the Plan and will receive copies of summary plan descriptions, summary annual reports and summaries of any amendments made to the Plan according to applicable law.

V. COBRA COVERAGE

In some circumstances, it may be possible for you and/or your dependents to continue coverage under the Plan when your coverage would have otherwise terminated.

A. COBRA CONTINUATION COVERAGE

If Plan coverage is terminated, you and/or your dependents may be entitled to continue coverage on a self-pay basis in accordance with The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours of covered employment.

Your spouse may elect and be considered a Qualified Beneficiary for COBRA continuation coverage if he or she loses coverage because of the occurrence of any of the following events:

- your death;
- your spouse's loss of coverage under the Plan due to voluntary or

involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours of covered employment;
- divorce or legal separation; or
- you become entitled to Medicare (even if such entitlement occurs while you and/or your spouse is already receiving COBRA continuation coverage).

Your dependent-child may elect and be considered a Qualified Beneficiary for COBRA continuation coverage upon the occurrence of any of the following events:

- your death;
- your dependent-child's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours of covered employment;
- divorce or legal separation of you and your spouse;
- you become entitled to Medicare (even if such entitlement occurs while you and/or your dependent-child is already receiving COBRA continuation coverage); or
- your dependent-child ceases to qualify as an "eligible dependent" according to the Plan.

B. NOTICE REQUIREMENTS

If, while you are receiving COBRA continuation coverage, you have a newborn child or adopt a child (or have a child placed with you for adoption), the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change. Such a child's coverage period will be determined according to the date of the qualifying event that gave rise to your COBRA coverage.

Under COBRA, you (or your spouse or dependent-child, if applicable) must notify the Fund Office within sixty (60) days after:

- You and your spouse are divorced or legally separated; or
- One of your dependent-children loses their dependent status under the Plan.

You (or your spouse or dependent-child, if applicable) will then be notified of your right to elect continuation coverage and the cost to do so.

C. DEADLINE TO ELECT COBRA

The deadline for electing continuation coverage is sixty (60) days after the later

of (i) the date that the Fund ceases to cover you; or (ii) the date that you have been notified that you are no longer covered by the Fund.

If you (or your spouse or dependent-child, if applicable) does not elect continuation coverage, your coverage will stop. If you (or your spouse or dependent-child, if applicable) choose continuation coverage, the Fund will provide coverage identical to that available to similarly-situated active employees, including the opportunity to choose among options available during open enrollment. However, you (or your spouse or dependent-child, if applicable) must pay the full cost of this coverage.

If a covered employee or their spouse elects COBRA without specifying whether the election is for self-only coverage, the election will be considered to be on behalf of all other Qualified Beneficiaries with respect to that qualifying event.

If the original qualifying event causing the loss of coverage was your death, divorce, legal separation, Medicare entitlement or loss of "dependent status" of a dependent-child under the Plan, then each Qualified Beneficiary will have the opportunity to elect a maximum of thirty-six (36) months of continuation coverage from the date of the qualifying event. If you (or your spouse or dependent-child, if applicable) loses coverage under the Plan because your employment was terminated or your hours of employment were reduced, then the maximum period will be eighteen (18) months from the date of the coverage loss. If during those eighteen (18) months, another qualifying event takes place that entitles you (or your spouse or dependent-child, if applicable) to continuation coverage, your continuation coverage (or that of your spouse or dependent-child) may be extended by another eighteen (18) months. However, in no event will continuation coverage extend more than a total of thirty-six (36) months from the date of the initial qualifying event.

Disability is a special issue. If the Social Security Administration or New York State Retirement System, as the case may be, determines that you (or your spouse or dependent-child, if applicable) is disabled during the first sixty (60) days of the continuation coverage period, or in the case of a child born to or placed for adoption with a covered employee during a COBRA coverage period, during the first sixty (60) days after a child's birth or placement for adoption, then your continuation coverage period (as well as your spouse's and any dependent's continuation of coverage period may be extended from eighteen (18) months to twenty-nine (29) months. To qualify, you (or your spouse or dependent-child, if applicable) must notify the Fund Office within sixty (60) days of the date of the Social Security or New York State Retirement System determination, and during the initial eighteen (18) month continuation coverage period. If there is a final determination that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Fund Office within thirty (30) days of the determination. Any coverage extended beyond the maximum that would otherwise apply will be terminated for all Qualified Beneficiaries.

D. AUTOMATIC TERMINATION OF COBRA CONTINUATION COVERAGE

Your (or your spouse's or dependent-child's, if applicable) right to continuation coverage under COBRA ends if:

- The Plan ceases to provide group health coverage;
- You (or your spouse or dependent-child, if applicable) fail to pay the premium within thirty (30) days after its monthly due date;
- You (or your spouse or dependent-child, if applicable) becomes covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your spouse or dependent-child, if applicable,) becomes entitled to Medicare after the date of the COBRA election;

- You (or your spouse or dependent-child, if applicable,) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claims submission, that would result in termination of coverage for similarly situated active employees.

E. WHO IS NOT A QUALIFIED BENEFICIARY?

A person is not a Qualified Beneficiary if, as of such day, such person is either (i) covered under the Plan by virtue of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or (ii) entitled to Medicare coverage under Title XVIII of the Social Security Act, or any applicable New York State Law. For these purposes, a Qualified Beneficiary is not considered to be "entitled" to Medicare until he actually has completed the Medicare enrollment process with the Social Security Administration and has been notified that his Medicare coverage is in effect. Further, a person who fails to elect Continuation Coverage within the Election Period shall not be considered to be a Qualified Beneficiary.

F. WHAT BENEFIT IS AVAILABLE UNDER CONTINUATION COVERAGE?

Each person who is eligible to elect to continue coverage shall have the right to continue the level of coverage in effect for the Covered Employee on the day before the Qualifying Event. If a Qualified Beneficiary of another group health plan is prevented from receiving the previous level of benefits due to a change in Plan

Benefits or Plan termination, such individual shall be entitled to elect any level of coverage available under this Plan.

G. ELECTION PERIOD

Any Qualified Beneficiary entitled to continuation coverage shall have sixty (60) days from the date on which regular coverage under the Plan would have terminated by reason of a Qualifying Event in which to return to the Fund Administrator a signed election of continuation coverage.

H. PREMIUM REQUIREMENTS

A Qualified Beneficiary who has elected continuation coverage hereunder, must pay a premium of one hundred and two (102%) percent of the applicable premium for the period of coverage.

The required premium for continuation coverage may, at the Qualified Beneficiary's election, be paid in monthly installments.

Premiums for continuation coverage become payable forty-five (45) days after the day on which the Qualified Beneficiary makes the initial election for Continuation Coverage.

I. DURATION OF CONTINUATION COVERAGE

Once elected, and subject to the premium requirements set out above, continuation coverage shall be retroactive to the date that coverage otherwise would have ended, and is the starting point for determining the remaining period for which the Plan must still continue to provide the individual or other Qualified Beneficiaries in his/her family with the opportunity for maintaining continuation coverage, i.e., 18 month, 29 months, or 36 months, as the case may be.

Such coverage shall extend for a period of eighteen (18) months after the date that regular coverage ends due to the covered employee's termination of employment or reduction of hours of employment to a level that disqualifies him/her from participation in the Plan, or for a period of twenty-nine (29) months if the Social Security Administration ("SSA") determines within the 18-month period that any Qualified Beneficiary was disabled during the first sixty (60) days of continuation coverage. If the covered employee was entitled to Medicare benefits at the time of the Qualifying Event of his/her termination of employment or reduction of hours, each covered dependent shall be eligible to continue coverage for up to thirty-six (36) months from the date that the covered employee first became so entitled. For purposes of determining continuation coverage rights, "entitlement" means actual enrollment for Medicare benefits.

In order to secure the extended coverage after a determination of disability, the disabled Qualified Beneficiary must notify the Fund Administrator of SSA's finding within forty-five (45) days of its issue. If, during the 18-month period, a subsequent Qualifying Event occurs, the covered employee and each other Qualified Beneficiary having continuation coverage shall be entitled to elect to continue coverage under the Plan for up to thirty-six (36) months following the date coverage was originally lost due to termination of employment or reduction of hours.

In addition, thirty-six (36) months of continuation coverage shall be available to: (i) the covered employee's spouse who loses coverage under this Plan by ceasing to be a "dependent" by virtue of a divorce or legal separation; (ii) a dependent-child of the covered employee who loses coverage by ceasing to be a "dependent" as defined by the Plan; (iii) any covered dependent who loses coverage where the Qualifying Event is the covered employee's death; or (iv) any covered dependent, where the covered employee's entitlement to Medicare benefits results in loss of coverage under this Plan. In no event, however, shall continuation coverage extend more than thirty-six (36) months beyond the date of the original Qualifying Event.

J. CONTINUATION OF COVERAGE FOR QUALIFIED MILITARY SERVICE

If you leave employment for full-time Qualified Military Service, as defined by federal law, you and your eligible dependents are permitted to elect to continue health coverage under the Plan, subject to certain limitations under federal law. This coverage, subject to the rules of the Plan, must last for up to eighteen (18) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the 18-month period if you enter Qualified Military Service and are discharged earlier and fail to make timely application for re-employment upon discharge.

If you elect such continuation, you will not be required to pay any premium for the first thirty (30) days of coverage. Thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan.

K. CONTINUATION OF COVERAGE UNDER THE FAMILY MEDICAL LEAVE ACT

Under federal law, you may be eligible for up to twelve (12) weeks of unpaid leave from your employment for any of the following reasons:

- you need to care for your newly-born or newly-adopted child;
- you need to care for your spouse, child or parent who has a serious health problem; or

- you have a serious health problem which prevents you from performing your job.

If you qualify for such a leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your work in covered employment had not stopped, unless your employer fails to make the required contributions for you. If you do not return to work at the end of your leave, you may be responsible for repaying the employer contributions made during the leave. You should contact your employer for further information about your eligibility for such a leave.

L. COVERAGE OPTIONS BESIDES COBRA

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

VI. TECHNICAL DETAILS

1. **PLAN NAME:** Suffolk County Court Employees Association Welfare Fund Active Plan of Benefits

2. **EDITION DATE:** This Edition is produced as of May 1, 2025.

3. **PLAN SPONSOR:** Board of Trustees of Suffolk County Employees Association Welfare Fund.

4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 11-250852

5. **TYPE OF PLAN:** Welfare Plan

6. **FISCAL YEAR:** April 1-March 31 (Benefit eligibility and claim submission

based on calendar year).

7. **FUND ADMINISTRATOR.** Board of Trustees.

8. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Archer, Byington, Glennon & Levine, LLP, 534 Broadhollow Road, Suite 430 Melville, NY 11747.

   In addition to the person designated as agent of service of legal process, service of legal process may also be made upon any Fund Trustee or the Fund Administrator.

9. **TYPE OF PLAN ADMINISTRATION:** Board of Trustees.

10. **TYPE OF FUNDING:** All benefits are self-insured except life insurance for active employees, which is insured. Assets are held in trust.

11. **SOURCES OF CONTRIBUTIONS TO PLAN:** New York State Unified Court System

12. **COLLECTIVE BARGAINING AGREEMENTS:** This Plan is maintained in accordance with a Collective Bargaining Agreement. A copy of this agreement may be obtained by you upon written request to the Fund Administrator and is available for examination by you at the Fund Office.

13. **PARTICIPATING EMPLOYERS:** You may receive from the Fund Administrator, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

14. **PLAN BENEFITS PROVIDED BY:** The Suffolk County Court Employees Association Welfare Fund.

May 1, 2025

SUFFOLK COUNTY
COURT EMPLOYEES ASSOCIATION
WELFARE FUND

1363-24 Veterans Memorial Highway
Hauppauge, NY 11788
(631) 231-3983 • FAX: (631) 231-3986

RETIREE PLAN OF BENEFITS

May 1, 2025

This booklet contains very important information concerning the benefits that you enjoy as a retiree participant under the Suffolk County Court Employees Association Welfare Fund (the "Fund").

All of the benefits offered by the Fund under this Retiree Plan of Benefits (the "Plan") are self-administered, and the Fund contribution levels are established through collective bargaining.

The Fund Trustees have worked consistently to maintain the benefits on a regular basis. We hope to continue to provide our members with these benefits and to continue Plan improvements whenever possible. Understand that the Trustees of the Fund reserve the right to amend, modify, and/or terminate the benefits offered by this Plan, should conditions so warrant.

If you have any questions regarding your benefits under the Plan, please contact the Fund office at (631) 231-3983.

John Tufarella,
Chairman

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SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND

Retiree Plan of Benefits

I. GENERAL INFORMATION

A. ENROLLMENT

Coverage for the benefits offered by the Suffolk County Court Employees Association Welfare Fund (the "Fund") under this Retiree Plan of Benefits (the "Plan") is not automatic. *In order to participate, eligible retirees must first enroll themselves and their eligible dependents in the Fund by completing and forwarding enrollment cards to the Fund office.* Enrollment cards can be obtained by calling the Fund office at (631) 231-3983.

All Plan participants/dependents must provide the Fund with their current address, and must provide adequate notice of any changes in their home address and/or contact information.

B. ELIGIBILITY FOR BENEFITS

In general, eligibility to participate in the Plan is based upon the criteria below. However, each specific benefit available under this Plan may have additional eligibility requirements.

The following are eligible ***participants*** in the Plan:

1. A retiree for whom the Fund is entitled to receive contributions from the State of New York.

The following are eligible ***dependents*** in the Plan:

1. The spouse of a Plan participant, provided that he or she is not legally separated from the participant.

2. The child of a Plan participant, ending the month in which the child turns age 26.

3. A domestic partner of a Plan participant. To qualify, the domestic partnership must be registered in the office of the county clerk in any county in New York State or in any similar registry in another jurisdiction.

4. An unmarried stepchild of a Plan participant who permanently lives with the participant and is supported by him or her pursuant to a court order awarding legal guardianship, provided that guardianship commenced before the child attained age 26.

5. An unmarried child of a Plan participant who is incapable of self-support, regardless of age, by reason of mental or physical disability and who became so disabled before reaching age 26.

6. An unmarried grandchild of a Plan participant who permanently lives with the participant and is supported by him or her pursuant to a court order awarding legal guardianship, provided that guardianship commenced before the child attained age 26.

7. Coverage may be extended past the age of 26 for an unmarried child who is a full-time student, had four (4) years of service in a branch of the U.S. Military between the ages of 19 and 25 and is not eligible for other employer group health coverage. Up to four (4) years of military service may be deducted for the child's age until the adjusted eligibility age equals 26.

C. WHEN ELIGIBILITY BEGINS

1. Eligible individuals who are granted retirement by the NYSERS within thirty (30) days of the last date upon which he or she was in full-pay status shall be entitled to Fund benefits upon enrollment, with no waiting period, so long as contributions are made on their behalf by New York State.

2. All other retirees (e.g., individuals with vested retirement rights and left service and individuals who were out of pay status for more than thirty (30) days awaiting the granting of an application for disability retirement) become eligible for enrollment on the first (1st) day of the month following sixty (60) days from the date that written notification of the granting of retirement benefits is received by the Fund, so long as contributions are being made on their behalf by New York State.

D. FILING OF CLAIMS

1. All claims for Fund benefits must be submitted on appropriate claim forms. Claim forms can be obtained by calling the Fund Office at (631) 231-3983, or online at www.sccea.org. All claims must be accompanied by any information or proof requested by the Fund

Office which is reasonably required to process the claim. All claims must be filed within the time frame required for that specific benefit.

2. Deadlines for Filing Claims

Plan Benefit	Deadline
• Dental • Hearing Aid • Optical • Health Expense Reimbursement	No later than December 31st of the calendar year in which the claim was incurred.
Death Benefit	No later than six (6) months after the date of loss.

3. Participating Providers

While the Trustees in no way endorse the use of Participating Providers, individuals may choose a participating provider who has agreed to provide specific benefits within the reimbursement allowances provided by the Fund for Dental, Optical, and Hearing Aid benefits. Participants are responsible for all charges for non-covered services. A list of providers and reimbursement allowances for Dental, Optical, and Hearing Aid benefits can be obtained from the Fund Office, Monday through Friday, (631) 231-3983, or online at www.asonet.com.

In the event that a participant/dependent uses any of the Fund's Participating Providers for Dental, Optical, and/or Hearing Aid benefits, claims may be submitted to the Fund directly by the Participating Provider.

E. TERMINATION OF BENEFITS

Benefits for participants cease at the end of the calendar month in which they cease to meet the Plan's eligibility requirements, or upon their death, whichever first occurs. Benefits cease for dependents at the time that benefits cease for the participant or when the dependent ceases to meet the Plan's dependent eligibility requirements, whichever first occurs.

F. COORDINATION OF BENEFITS

Coordination of benefits provides that each Fund benefit is coordinated with any other plan under which an individual is covered so that the total benefits available will not exceed 100% of the reasonable and customary charges or the actual charges, whichever is less. The plan covering the participant directly is

the primary plan. If a dependent-child is covered under another plan, the plan of the parent whose birthday comes first in the calendar year is the primary plan; however, if the parents are divorced or legally separated, except as provided by a Qualified Medical Child Support Order (QMCSO), the plan of the parent with custody pays benefits first.

All Fund benefits available under this Plan must be coordinated with any other plan which provides coverage. Where both spouses are eligible Plan participants, their dependent-children will be covered to a maximum of the normal, reasonable and customary charges or the actual charges, whichever is less, available through the combined coverage of both spouses. The claims of both spouses must be submitted together.

G. PAYMENT

The procedures for payment of benefits vary. Payments are made either to the participant directly or to the provider for the particular service. Payments are made in accordance with the level of benefits provided in this Plan, and the Fund is not responsible for any amounts due in excess of Plan provisions.

H. CHANGES IN THE PLAN

The Trustees may add to, amend, change, delete or modify benefits as well as the rules, regulations and procedures of this Plan.

II. PLAN BENEFITS

DEATH BENEFIT

A. Who Is Eligible

Participants.

B. Benefit Defined

The Fund will provide a $2,000.00 death benefit, self-funded by the Fund, for all participants who file a death benefit enrollment card and who are no longer eligible for Life Insurance coverage as an active employee under the Fund's Active Member Plan of Benefits. This benefit is subject to income tax.

C. Filing Requirements

A claimant must provide written proof of loss no later than six (6) months after the date of loss.

DENTAL BENEFIT

A. Who Is Eligible

Participants and eligible dependents.

B. Benefit Defined

1. Non-Orthodontic

Payment will be made for each dental service up to the amount provided under the Schedule of Covered Dental Expenses. This Schedule is contained in a separate pamphlet. There is a $2,500.00 annual per person maximum for non-orthodontic services in a calendar year. In case of treatment of pediatric dentistry, treatments shall be paid per schedule.

2. Orthodontic

There is a separate benefit for orthodontic services with a lifetime per person maximum of $1,995.00. Pediatric orthodontic treatments shall be paid per schedule.

C. Pretreatment Review

The Pretreatment Review Program is designed to give participants/dependents and dentists a better understanding of the Schedule of Covered Dental Expenses payable under the Plan before services are provided. Dentists should submit a pretreatment review claim form for crowns, bridges, dentures or when services are expected to exceed $300.00. The Fund will then determine the benefits which will be payable for each dental service and return the approved claim to the dentist.

If this Pretreatment Review Program is not followed, payment will be determined by taking into account alternate procedures or services, based on acceptable standards of dental practice.

D. Dental Emergencies

If a participant/dependent has a dental emergency for which a Participating Provider is not reasonably available and the participant/dependent uses a non-participating provider, the Trustees may authorize the Fund to reimburse an amount not to exceed the amount which the Fund would have paid to a Participating Provider who performed the same services under the Plan.

HEARING AID BENEFIT

A. Who is Eligible

Participants and eligible dependents.

B. Benefit Defined

1. The Fund will pay one (1) claim every four (4) calendar years towards the cost of a hearing aid for each person eligible for this benefit, up to a maximum of $525.00 per person, commencing with the first year of service. Covered expenses are limited to charges for the cost and installation of a hearing aid as prescribed by an Otologist, Audiologist or Physician.

2. The Fund will pay one (1) claim every four (4) calendar years for the repair of a hearing aid, up to a maximum of $75.00 per person.

3. The benefits are non-cumulative.

C. Exclusions

1. Expenses for which benefits are payable under Workers' Compensation Law.

2. Expenses for which benefits are payable under Medicare or other Government plan.

4. Special procedure training, such as lip reading courses, schooling or institutional services.

5. Medical or surgical treatment of the ear or ears.

D. Coordination of Benefits

This benefit must be coordinated with any health insurance or other plan which provides coverage for hearing aids and proof of such coordination (EOB from primary insurance) showing out-of-pocket expense must be submitted with the claim.

OPTICAL BENEFIT

A. Who Is Eligible

Participants and eligible dependents.

B. Benefit Defined

The Fund will reimburse up to $150.00 in any calendar year for each eligible participant/dependent for optical services obtained from any licensed optometrist, ophthalmologist or optician. Reimbursement for all claims shall be based on a one-time payment per person in any calendar year.

HEALTH EXPENSE REIMBURSEMENT BENEFIT

A. Who is Eligible

Participants only.

B. Benefit Defined

The Fund will reimburse participants up to an annual maximum of $200.00 per calendar year for the following expenses that they incur:

1. Health Insurance co-payments.

2. Prescription Drug benefits.

C. Claim Filing Requirements

Claims can be submitted at any time until the maximum is met, but not later than December 31st of the year in which eligible health expense was incurred.

To receive reimbursement of eligible health expenses, participants must complete the appropriate claim form and send it to the Fund Office along with all supporting original documentation (Explanation

of Benefits (EOB)) or other proof that will verify the claim. No reimbursement will be made without, at a minimum, (1) a written statement of an independent third-party such as an EOB stating that the expense had been incurred and the amount of the expense; and (2) a written statement and documentation (e.g., pharmacy receipts or printouts with relevant information) from the participant that the expense has not been reimbursed and is not reimbursable under another health plan coverage. **No reimbursement of eligible health care expenses under this benefit provision shall be made if such expenses have been reimbursed by any other health care insurance, provider or entity.**

III. CLAIM REVIEW PROCEDURE

1. Notice of any decision by the Fund Trustees to deny a claim for benefits under this Plan must be provided within sixty (6o) days of the Fund's receipt of the claim. If the Fund is unable to make a decision within that time due to circumstances beyond the Fund's control (such as late receipt of medical records), it must notify the participant/dependent before expiration of the original sixty (60) days that it intends to extend the time, and then may take as long as thirty (30) additional days to reach a decision. If the Fund Trustees need the 30-day extension because the participant/dependent did not provide all of the information needed to process their claim, the Fund will identify what information is missing.

2. If an individual's claim is incomplete, they must provide the Fund with the additional information by no later than forty-five (45) days from the date that the notification was mailed by the Fund regarding the incomplete claim. If an individual fails to send the Fund the missing information within this 45-day period, the Fund will deny the claim.

3. If, for any reason, a benefit claim is denied, a Notice of Initial Claim Denial will be provided by the Fund. The manner and content of this notice will include the following:

a. The specific reasons for the denial;

b. Reference to the specific Plan provision being relied on;

c. Any additional information that is required to complete the claim and an explanation as to why the information is required; and

d. A description of the Plan's review procedures and time limits.

4. An individual who has received a notice that their benefit claim has been denied may request a review of the denied claim within one hundred and eighty (180) days of the receipt of the notice of denial. Participants/dependents will have reasonable access to and copies of, upon request and free of charge, all documents, records and other relevant information related to the claim. The review will take into account everything submitted by the individual (whether submitted in the original claim or not).

5. Requests for a review of a claim must be made in writing and sent to the Fund Office, which will act as follows with respect to the claimant's transmittal:

a. Send a copy to the insurance organization if an insured benefit is involved, or

b. Bring it to the attention of the Board of Trustees in the case of benefits provided directly by the Fund on a self-insured basis.

6. If the request for review involves a claim for benefits that are provided directly by the Fund on a self-insured basis, the Board of Trustees will render a decision within sixty (60) days after the receipt of the request for the review, unless special circumstances require an extension of time, in which case a decision will be rendered within ninety (90) days. The decision of the Board of Trustees will be in writing. The Trustees shall have exclusive authority and discretion, among other things, to interpret the provisions of the Trust Agreement and of the Plan.

IV. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled "alternate payees". Both participants and their dependents can obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Administrator.

Upon receipt of a Qualified Medical Child Support Order, the Fund Administrator will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be

considered a participant under the Plan and will receive copies of summary plan descriptions, summary annual reports and summaries of any amendments made to the Plan according to applicable law.

V. COBRA COVERAGE

If a participant dies or becomes divorced or legally separated, or a dependent ceases to be a dependent under the Plan's eligibility requirements, the spouse and/or dependent may have rights to continue certain Plan coverage on a self-pay basis in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If any of the events set forth above occurs, the participant or dependent MUST inform the Fund of the qualifying event WITHIN sixty (60) days of the later of the qualifying event and the date on which coverage would be lost because of the event. The rules of COBRA coverage will be provided by the Fund.

VI. TECHNICAL DETAILS

1. **PLAN NAME:** Suffolk County Court Employees Association Welfare Fund Retiree Plan of Benefits.

2. **EDITION DATE:** This Edition is produced as of May 1, 2025.

3. **PLAN SPONSOR:** Board of Trustees of Suffolk County Employees Association Welfare Fund.

4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 11-2504852.

5. **TYPE OF PLAN:** Welfare Plan.

6. **FISCAL YEAR ENDS:** April 1 - March 31 (benefit eligibility based on calendar year).

7. **FUND ADMINISTRATOR:** Board of Trustees.

8. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Archer, Byington, Glennon & Levine, LLP, 534 Broadhollow Road, Suite 430, Melville, NY 11747.

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14. **PLAN BENEFITS PROVIDED BY:** The Suffolk County Court Employees Association Welfare Fund.