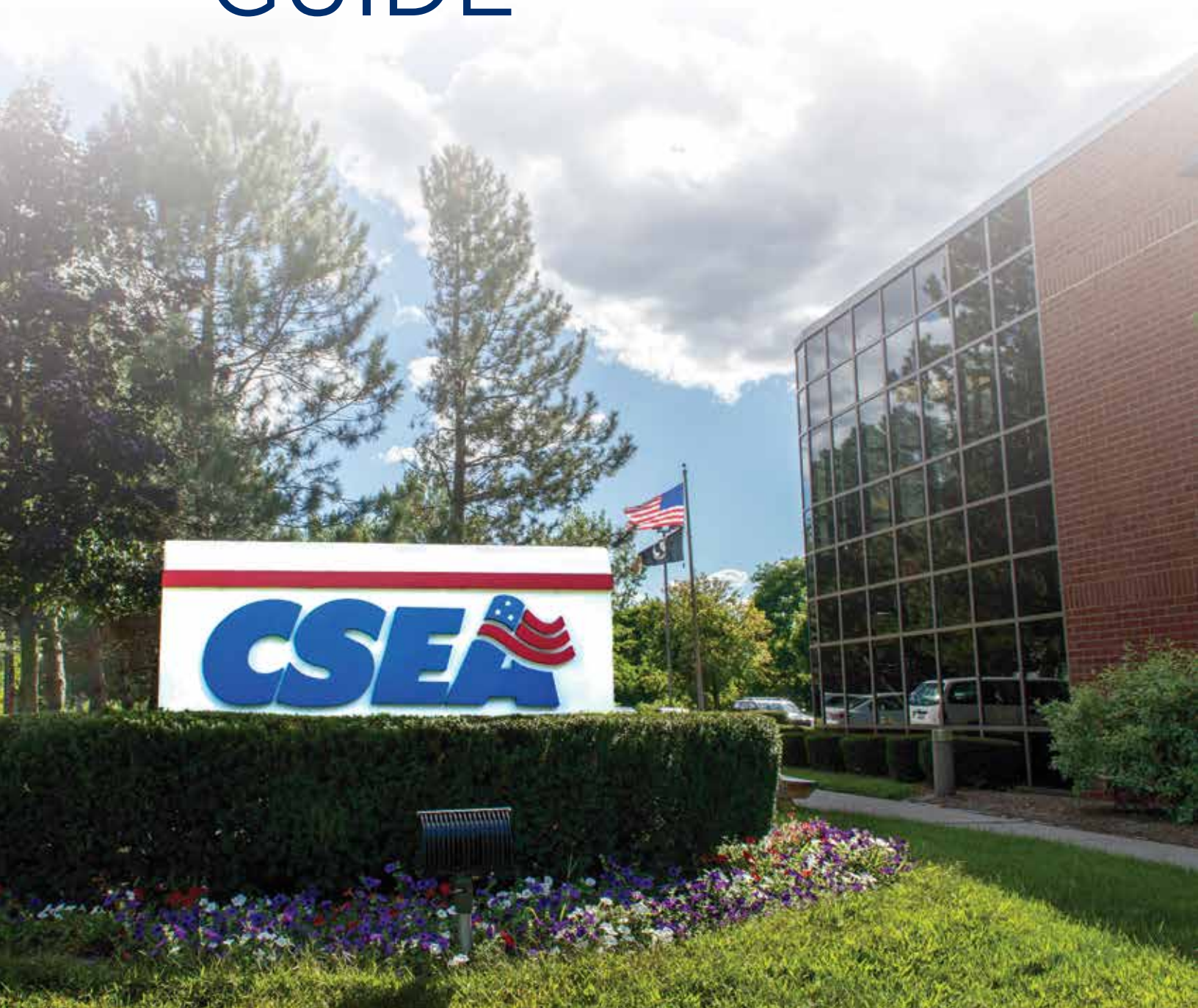
CSEA EMPLOYEE BENEFIT FUND

CSEA EMPLOYEE BENEFIT FUND'S

BENEFIT ADMINISTRATOR GUIDE



CSEA EMPLOYEE BENEFIT FUND

Dear Benefit Administrator,

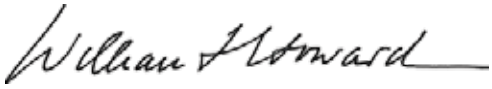
The CSEA Employee Benefit Fund (EBF) has been providing quality benefits at an affordable price since 1979. The EBF is a not-for-profit labor trust that offers dental and vision coverage as well as a select offering of reimbursement benefits to the CSEA membership and their families. The benefits are collectively bargained, and because of our structure, the benefits are priced as competitively as possible while still being able to maintain a strong network of providers.

This guide is intended to serve as an introduction to the EBF and covers such topics as a general summary of benefit offerings, how billing documents are formatted, and some of the various forms that a Benefit Administrator might need. These forms can be photocopied from this booklet or downloaded from our website, www.cseaebf.com.

The website includes all of the EBF's plan booklets for dental and vision as well as descriptive narratives on other benefits such as physician co-pay reimbursement, prescription drug co-pay reimbursement, hearing aid, maternity and legal benefit offerings. Plan members can also look up their EBF ID number, print new EBF Benefit Cards and LiveChat with our staff.

The EBF's primary mission is to provide our members with quality benefits as well as ensure our commitment to our network of participating providers. The public sector is under tremendous fiscal pressure and the EBF works hard to maintain a quality benefit program at the lowest possible cost. Should you have any questions, please do not hesitate to seek the advice of our Marketing Department. The most updated listing for staff assigned to your region can be found on our website or by calling 800-323-2732.

Sincerely,



Bill Howard
Director

The CSEA Employee Benefit Fund (EBF) is a not-for-profit labor trust managed by a Board of Trustees comprised of CSEA members. Our office is located at One Lear Jet Lane, Suite One, in Latham, New York. The EBF administers Dental, Vision, Legal, Hearing Aid, Maternity, Prescription Drug Co-Pay Reimbursement, Physician Co-Pay Reimbursement, and Workplace Security benefits to State and Local Government CSEA members and their dependents. Benefits are obtained through contract negotiations between the CSEA bargaining unit and the employer.

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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the type of information we can discuss about your employees.

In some circumstances we may have to have your employee, their spouse, or their dependents who are age 18 and over call us directly unless we have a signed HIPAA Release Form on file. See page 12 for a sample form. Copies can be downloaded from our website www.cseaebf.com.

HIPAA Release Forms will remain in effect until revoked by the applicant or upon termination of enrollment in the benefit plan. For questions regarding HIPAA, please contact Bill Ryan, our HIPAA Compliance Officer, at extension 804.

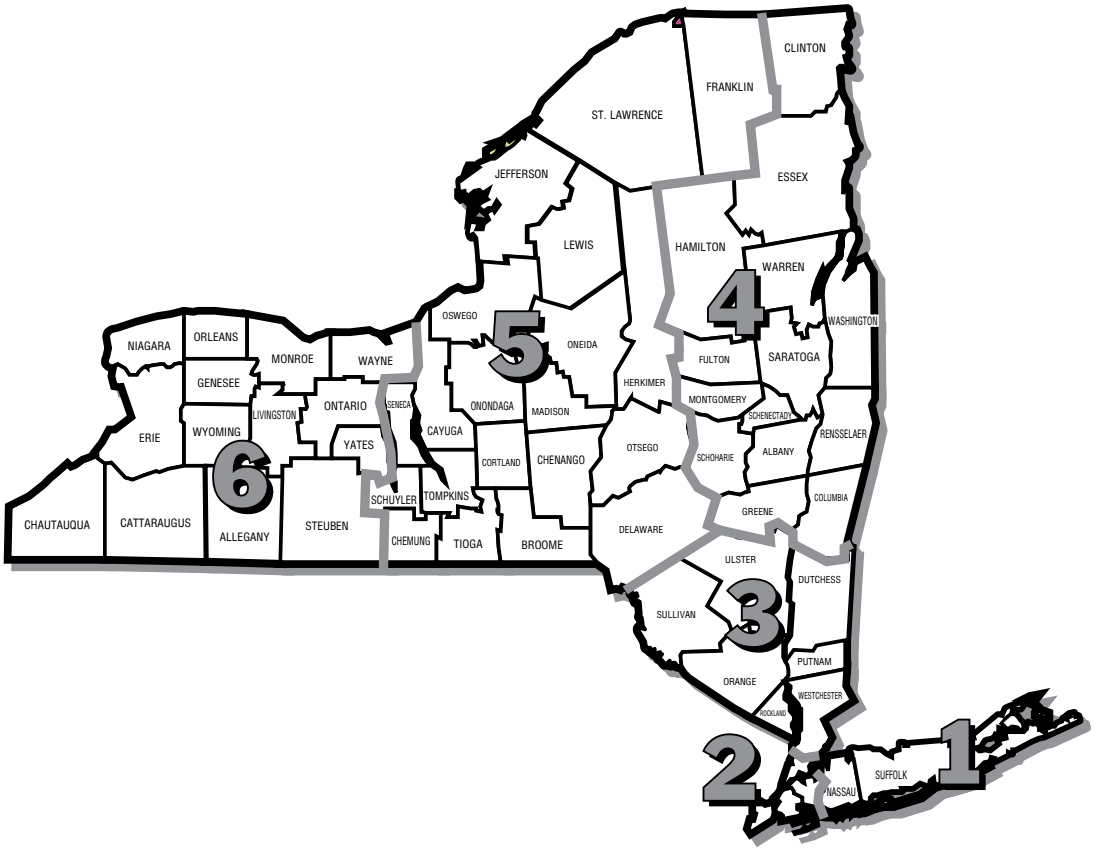
CONTACT INFO FOR PLAN ADMINISTRATORS

Hours of operation are 7:30 am - 5:00 pm Monday thru Friday

CSEA Employee Benefit Fund
1 Lear Jet Lane, Suite 1
Latham, NY 12110
Phone: **(800) 323-2732**

Have a question? Need supplies or someone to attend a health fair or information day? Contact your Local Government marketing representative. Our knowledgeable sales staff can also customize presentations to fit the needs of your employees.

Region 1 Linda Sclafani	(631) 462-5224	lsclafani@cseaebf.org
Region 3 Jordan Hughes	x800	jhughes@cseaebf.org
Region 4 Erin Bazinet	x860	ebazinet@cseaebf.org
Region 5 Geoff Switts	x813	gswitts@cseaebf.org
Region 6 Jim Aldrich	x818	jaldrich@cseaebf.org



CONTACT INFO FOR PLAN MEMBERS

Phone: **(800) 323-2732** **Scan and email forms to **ole@cseaebf.org***

DIRECTORY

Dental Benefit Information	Press 2
Request a Replacement Card	Press 3
Request Summary Plan Descriptions or Provider Listings	Press 3
COBRA & Retiree Dental Information	Press 4
Vision Benefit Information	Press 5
Reimbursement Benefit Information	Press 5
Update Account Information	Press 5
Add a Dependent	Press 5
Student Proof Information	Press 5

FAX NUMBERS

Member Services	(518) 786-3658
Marketing Department	(518) 782-9979

ELIGIBILITY

EBF eligibility is dependent upon the unit's Collective Bargaining Agreement (CBA) and is initiated through the employer. Upon successful completion of negotiations providing for benefits through the EBF, three copies of a separate EBF contract are sent to the employer outlining terms and conditions.

FOR BENEFIT RENEWAL

All three signed copies of the EBF contract must be returned to the EBF. Upon receipt the EBF will execute the agreement and return a copy to the employer for your records.

FOR NEW BENEFITS

All three signed copies of the EBF contract must be returned to the EBF with a list of the covered employees' names, addresses, social security numbers and completed EBF Enrollment Forms. This material is used to create computer files for the covered employees. Upon the opening of the unit file, a copy of the fully executed contract is forwarded to the employer.

The EBF does not have waiting periods for enrollment. If the employer has a waiting period, please do not add an employee until they have met the established waiting period.

MONTHLY INVOICE

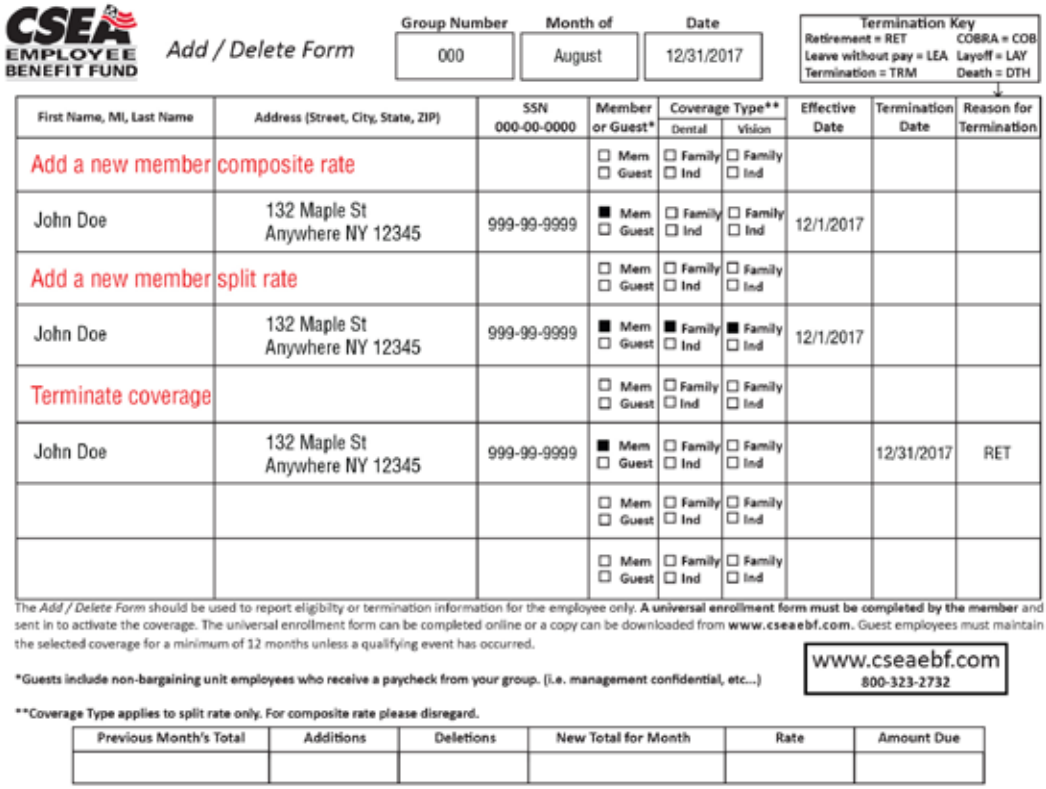
The initial invoice will be sent to the employer upon receipt of a fully executed copy of the EBF contract. The employer will be billed for benefits provided on a monthly basis. The monthly invoice lists the amount being billed, the plans that are being billed for and a list of employees who are currently enrolled. It is the employer's responsibility to check the invoice for accuracy and notify the EBF of any discrepancies by listing them on the Add/Delete Form.

The Add/Delete Form should be used to report eligibility or termination information for the employee only. **The EBF Enrollment Form must accompany the Add/Delete Form for groups that have split rate benefits or Solstice benefits.** All dependent updates should be reported by having the employee complete an EBF enrollment form.

Invoices are printed on the 15th of each month for the following month. Eligibility changes made after the 15th will reflect on the invoice for the month after. All changes between billing periods must be made in writing. Please include the name, address, social security number and month of eligibility or month of termination with the reason for termination. Changes may also be faxed to the Member Services Department at (518) 782-1267.

E-mails are acceptable and may be sent to elig@cseaebf.org.

The following example is our most common Add/Delete Form. If you receive another version of the Add/Delete Form and have questions on how to complete it please contact elig@cseaebf.org.



CSEA EMPLOYEE BENEFIT FUND

Add / Delete Form

Group Number	Month of	Date
000	August	12/31/2017

Termination Key
Retirement = RET | COBRA = COB
Leave without pay = LEA | Layoff = LAY
Termination = TRM | Death = DTH

First Name, MI, Last Name	Address (Street, City, State, ZIP)	SSN 000-00-0000	Member or Guest*	Coverage Type** Dental	Coverage Type** Vision	Effective Date	Termination Date	Reason for Termination
Add a new member	composite rate		☐ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind			
John Doe	132 Maple St Anywhere NY 12345	999-99-9999	■ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind	12/1/2017		
Add a new member	split rate		☐ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind			
John Doe	132 Maple St Anywhere NY 12345	999-99-9999	■ Mem ☐ Guest	■ Family ☐ Ind	■ Family ☐ Ind	12/1/2017		
Terminate coverage			☐ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind			
John Doe	132 Maple St Anywhere NY 12345	999-99-9999	■ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind		12/31/2017	RET
			☐ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind			
			☐ Mem ☐ Guest	☐ Family ☐ Ind	☐ Family ☐ Ind			

The *Add / Delete Form* should be used to report eligibility or termination information for the employee only. **A universal enrollment form must be completed by the member** and sent in to activate the coverage. The universal enrollment form can be completed online or a copy can be downloaded from **www.cseaebf.com**. Guest employees must maintain the selected coverage for a minimum of 12 months unless a qualifying event has occurred.

www.cseaebf.com
800-323-2732

*Guests include non-bargaining unit employees who receive a paycheck from your group. (i.e. management confidential, etc...)

**Coverage Type applies to split rate only. For composite rate please disregard.

Previous Month's Total	Additions	Deletions	New Total for Month	Rate	Amount Due

ENROLLMENT

Prior to a employee submitting an enrollment form, the employer must notify the EBF of the employee's name, address, social security number* and eligibility date in writing via mail, fax, or e-mail.

Enrollment forms cannot be processed without the initial submission of employer information. **The EBF Enrollment Form must accompany the Add/Delete Form for groups that have split rate benefits or Solstice benefits.** See page 11 for a sample enrollment form. There is a separate enrollment form for Solstice benefits.

New employees will be mailed all enrollment materials by the EBF. The EBF requires employee signatures on all enrollment forms.

Employees who have a change in dependent status must notify the EBF by phone call and may have to provide proof in writing, e.g. Marriage, Birth, Dependent Child above age 19, Legal Separation, Divorce, and Death.

Employees who change coverage from individual to family coverage must maintain family coverage for 12 months from date of effective coverage, unless a qualifying event has occurred.

Enrolled guests (i.e. management confidentials and other non-bargaining unit members are referred to as "guests") are to be aware that they are required to continue coverage for a minimum of one year of coverage unless there is a qualifying event.

The employer cannot change dependent information for employees. It is the responsibility of the employee to make any and all changes to their dependent file by contacting the EBF.

Benefit coverage begins with the effective start-up date of the contract for the bargaining unit. An enrollment form must be completed and returned to the EBF in order to submit any claim for benefits to the EBF.

Enrollment for dependents age 19 and over require full-time student verification each year to continue coverage. Student proof runs September – August and must be renewed annually with the EBF. See pages 13 & 14 for a sample form.

For split rate benefits or Solstice benefits your invoice will automatically be adjusted when a dependent becomes ineligible. This may create a change in the rate tier.

Proof of dependency may be required for dependents in certain instances. When a member and dependent spouse or child do not have the same last name, a copy of the marriage certificate or birth certificate must be submitted with the enrollment form.

*Although the EBF now uses a secure member ID number, the social security number is necessary to activate initial membership and eligibility for benefits.

Eligible employees who retire, are terminated or leave service may continue benefits on a direct pay basis either with the EBF or directly with the employer. Former employees may continue coverage under the EBF provided they maintain the bargaining unit's current benefits. Employees must elect to continue coverage within 60 days from their last day of employment. The employee pays the premium cost directly to the EBF or to the employer. Eligible employees can carry COBRA for up to 36 months.

DOMESTIC PARTNER COVERAGE

The EBF does not establish the criteria for domestic partner coverage as it is the responsibility of the employer. If this coverage is offered through the employer, the employer must report the eligibility for individual domestic partners in writing. This notice should include the employee name, SSN and the effective date of the partner's coverage. Upon receipt of this eligibility notice, the EBF will send enrollment materials to the employee in order to complete the enrollment process.

Should the domestic partner no longer be eligible for coverage, it is the employer's responsibility to notify the EBF in writing. Please include the employee name, SSN and termination date of the partner's coverage. Please advise the employees with domestic partner coverage that they are required to report the removal of their partner to the employer.

The EBF is required to report to the IRS the imputed value of the EBF benefit of a Domestic Partner, and a 1099 is issued to the member each calendar year for this amount.

SAME SEX MARRIAGE

Persons of the same sex to whom the covered employee was married in a marriage ceremony legally performed in a jurisdiction permitting same sex marriage can be submitted. A copy of the marriage certificate must accompany the EBF enrollment card. If an employee changes from individual to family coverage, the change in status must be reflected on the Add/Delete Form.

CSEA EMPLOYEE BENEFIT FUND ID CARDS

After the employee is fully enrolled (Add/Delete Form + enrollment form) an ID card with a randomly generated nine digit number will be sent to the member. The EBF ID number must be used for claim submission. When an employee/dependent calls with a question our customer service staff can search our internal system by Name, EBF ID number, or SSN. HIPAA guidelines apply.

CSEA EMPLOYEE BENEFIT FUND WEBSITE

At **www.cseaebf.com** you and your employees can view the latest news, download all of our forms, download plan summary descriptions, search providers, order replacement member ID cards, and communicate with one of our specialized customers service representatives; with our Live Chat feature. With our Provider Search feature you always have access to the latest listing of participating providers. You can search by name, address, CSEA Region or by specialty. If a card is lost, please click on the "Look Up Your EBF ID #" button and you will be able to print a new card or order a replacement.

Take advantage of our wide array of benefits that can be added to your existing EBF benefit package. To discuss the following options please contact your EBF Marketing Representative. Their contact information is located on page 3.

Dental Benefits with Annual Maximums from $2,850 - $3,210 per person.

Vision Benefits that offer full coverage for covered services at participating providers.

Prescription Drug Co-Pay Benefits that pay up to $200 - $500 per family per calendar year.

Physician Co-Pay Benefits that pay up to $120-$150 per family per calendar year.

Hearing Aid Benefits that pay up to $450 per ear once every three years.

Maternity Benefits that pays $200 per birth for members or their spouses.

Legal Reimbursement Benefits that pay up to $1000 per family per calendar year.

The Solstice Dental and Vision Plans are voluntary benefits that are an option for groups that are unable to meet the EBF's 50% minimum participation level.

SOLSTICE DENTAL PLAN

The Solstice Dental Plan provides members and their eligible dependents with a plan maximum of $1,800 per person per calendar year.

The Solstice Dental Plan includes coverage for diagnostic, preventive, basic & major restorative, endodontics, periodontics, prosthodontics, oral surgery and orthodontics for dependents under age 19. Participating providers accept this plan as full payment for covered services. There are no deductibles or co-payments in or out of our provider network. A six month waiting period is applied for major services, and these are clearly outlined in the Plan Summary Description.

SOLSTICE VISION PLAN

The Solstice Vision Plan entitles members and their eligible dependents to an eye exam and a pair of lenses and frames or an initial supply of contact lenses once every 12 months.

Members using a participating provider pay no out-of-pocket expenses provided they stay within the established lens and frame collection.

RETIREE BENEFITS

A Retiree Dental and/or Vision Program is available to employees who were previously covered by an EBF dental and/or vision program through their union contract. A separate Retiree Memorandum of Agreement (MOA) must be signed by the employer for employees to access these programs. Access to the retiree programs is driven by the date the MOA is signed by the employer. Retirees who left employment prior to the executed MOA are not eligible for participation in the program(s). This agreement is an addendum to the union contract and enables the EBF to contract and collect rates directly from the retiree. There is no financial or administrative responsibility on the part of the employer. Eligibility information is sent by the EBF directly to the retiree upon receipt of termination due to retirement from the employer.

RETIREE DENTAL PLAN

The Retiree Dental Plan provides a $1,800 annual maximum per person per calendar year. Areas of coverage include diagnostic, preventive, restorative, endodontics, periodontics, prosthodontics and oral surgery. Participating providers accept the program as payment in full for covered services.

RETIREE VISION PLAN

The Retiree Vision Plan offers retirees and eligible dependents (if dependent coverage is elected) a routine eye exam and one pair of eye glasses OR start up supply of contact lenses once every 12 months. Retirees using a participating vision provider and staying within the lens and frame selection pay no out-of-pocket expenses at the provider office. The provider network includes 10,000+ offices through the United States. A Fixed Co-payment Discount is offered for services not covered under the program at the provider office.

CSEA Employee Benefit Fund Enrollment Form

PO Box 516
Latham, NY 12110
800-323-2732
www.cseaebf.com

Employee Information (Please Print)

Social Security # _____ Date of Birth _____/_____/_____

Name (First, Middle Initial, Last) _____ Please (✓) one: ❑ M ❑ F

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Employee's Daytime Phone # _____ Email _____

Name of Employer _____

Spouse/Domestic Partner Information

Please (✓) one: ❑ Spouse ❑ Domestic Partner* Date of Marriage _____/_____/_____ Please (✓) one: ❑ M ❑ F

Name (First, Middle Initial, Last) _____

Date of Birth _____/_____/_____ Social Security # _____

Dependent Children Information (For relationship, please indicate: Son, Daughter, Step-child or other)

Last Name _____ First Name _____ Date of Birth _____/_____/_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____/_____/_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____/_____/_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____/_____/_____ ❑ M ❑ F Relationship _____

If you are enrolling for a CSEA EBF Dental Plan, please answer the following: Do you and/or your dependents have other dental coverage available? ❑ Yes ❑ No

If yes, please indicate: Name of other plan: _____ Effective Date: _____/_____/_____

*Important Information concerning dependent coverage

- *Not all employers allow domestic partner coverage.* For New York State Employees; before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from The NYS Department of Civil Service. For Local Government employees, the confirmation must come from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
- When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional infomation which may include full-time student verification for children ages 19 and over, verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
- In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
- An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.

For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com

I certify that the above information is correct:

Member's Signature _____ Date _____

CSEA Employee Benefit Fund
HIPAA Authorization Form

The CSEA Employee Benefit Fund requires a signed HIPAA waiver from all persons 18 and older in order for the EBF to release that individual's protected health information (PHI) to a third party.

TO BE COMPLETED (PLEASE PRINT)

Member's Name _____ EBF ID# _____

Applicant Name*_____ Date of Birth _____

The Applicant is the individual authorizing the release of their protected health information to a third party.

TO BE COMPLETED BY APPLICANT

A. Please indicate the type(s) of protected health information that you wish to authorize the CSEA Employee Benefit Fund to use or disclose:

Dental ☐ Vision ☐ Miscellaneous Claims Benefits ☐

B. Please indicate the name and date of birth of the person(s) that you are authorizing the CSEA Employee Benefit Fund to release this information to:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

C. I understand that I may revoke this Authorization at any time. This Authorization will remain in effect until revoked by the Applicant or upon termination of enrollment in the benefit plan. To revoke Authorization, I understand that I must contact the following in writing:

CSEA Employee Benefit Fund
c/o HIPAA Privacy Officer
PO Box 516
Latham, NY 12110-0516

D. Authorization and Signature: I authorize the release of my confidential protected health information pursuant to my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made to conform to my directions. I understand that this protected information may be subject to redisclosure by a third party and hence no longer protected. I have read the contents of this Authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

Signature _____ Date _____

MAIL COMPLETED FORM TO

CSEA Employee Benefit Fund
PO Box 516
Latham, NY 12110-0516

Dear Member,

Our enrollment records indicate that you have a dependent child enrolled who is age 19 or over. Coverage for this dependent may be continued up to his/her 25th birthday if a full-time student. Coverage terminates three months from the end of the month in which the student completes graduation requirements or the 25th birthday, based on whichever event comes first.

Student status certification is required annually as the Dental and Vision benefits are not affected by the Federal Health Care Reform Act.

To qualify for continued coverage, the dependent must be a full-time student enrolled for a minimum of 12 undergraduate or 6 graduate credit hours in an accredited college or university. The dependent must be working towards a formal degree such as an Associate Degree (A.A. or A.S.), Bachelor Degree (B.A. or B.S.) or Master Degree (M.A. or M.S.). Full-time high school students also qualify. Technical courses for a short duration do not meet this requirement.

To certify your dependent as a full time student, please complete the form on the reverse side and return it to the CSEA EBF.

Thank you,

Member Services Department
CSEA Employee Benefit Fund

CSEA EMPLOYEE BENEFIT FUND

DEPENDENT STUDENT CERTIFICATION FORM 2016-2017

MAIL TO: PO Box 516, Latham, New York 12110
OR FAX TO: (518) 786-3658
(800) 323-2732 | **WWW.CSEAEBF.COM**

Member Name: _____

CSEA EBF ID #: _____

Member Phone #: _____

Member Email: _____

I certify that my dependent student listed below meets all of the following requirements for eligibility as a dependent student:

Student Name: _____

Student Date of Birth: _____

A. Is the dependent student married? Yes ❒ No ❒

B. Semester(s) enrolled: Fall 2016 ❒ Spring 2017 ❒

C. Is a full-time student in high school or college/university.* Yes ❒ No ❒

D. Expected date of graduation: _____ /_____ /_____

PLEASE PRINT CLEARLY

Student Name

School Name

School Address

School City State Zip Code

School Phone - -

*The dependent child or ward must be enrolled in a minimum of 12 undergraduate or 6 graduate credit hours to be considered full time. Courses must be from a regionally accredited college or university and working toward an Associate's Degree (e.g., A.A. or A.S.), Bachelor's Degree (e.g., B.A. or B.S.) or Master's Degree (e.g., M.A. or M.S.). Technical courses of short duration do not qualify, even if a diploma is awarded.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in a delay, denial or termination of coverage for the above-named dependent. I understand that CSEA Employee Benefit Fund reserves the right to ask for more information as proof of the above-named dependent's full-time student status.

I agree to advise CSEA Employee Benefit Fund promptly of any changes in my child's dependent student status.

Member's Signature _____ Date _____

CSEA EMPLOYEE BENEFIT FUND

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