Letter From Chairman

Dear Member:

As Chairperson of the Security Benefits Fund, I am pleased to provide you with the following information containing important information on the benefits negotiated by your Union and provided through the Fund.

It is our goal to have all our members familiar with all the benefits that are provided through the Security Benefits Fund. Please read this booklet carefully and keep it in a convenient place for handy reference in the event that you need to take advantage of its benefits.

In addition, should you have any questions concerning the plan or require assistance, please do not hesitate to contact the Fund Office at 212-941-5700.

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

Fraternally,

Glenn L. Damato

Outline of Benefits

Dental Benefit – This benefit provides coverage for general dentistry, prosthetics and orthodontia.

Optical Benefit – This benefit provides an eye examination and one pair of glasses each calendar year.

Death Benefit – Effective December 1, 2006, the Fund provides a:

- $25,000 active member death benefit
- $10,000 spouse death benefit
- $5,000 death benefit per eligible dependent child

Maternity Benefit – Effective January 1, 2007, The Fund will reimburse the member $1,000, over and above any insurance benefit received in maternity cases.

Adoption Benefit – Effective January 1, 2007, The Fund will reimburse a member up to $1,000.00 towards the cost of a legal adoption.

Inner Imaging Full Body Scan – Electron Beam Tomography Screening available to member and spouse. Allowable once every five years.

Annual Physical Examination – The Annual Physical Examination is provided by Manhattan Internal Medicine Associates, P.C. The member and spouse are covered at no cost. No voucher is necessary, just call and make the appointment. Visit the link section for contact information.

Hearing Aid – The Fund will provide a hearing aid benefit for member and eligible dependents. The benefit is payable once every four years and will be for $400 for each ear to cover the cost for an examination and appliance. This benefit will be offset by any reimbursement from any insurance plan. A claim form is necessary and is available from the Fund Administrator.

Supplemental Hospital-Medical Benefit – Effective April 1, 2007, the Fund will make a reimbursement of $100 per overnight stay to any member or spouse who is confined in a hospital up to a total maximum reimbursement of $1,500 per year. The supplemental Hospital-Medical benefit is not payable for Maternity Cases.

Disability Benefit – See document below:

NEW-EFFECTIVE 1/1/17

DISABILITY BENEFIT

Who is covered?

All active full-time Court Clerks are eligible for a benefit under our disability program, which became effective January 1, 1991.

The plan will pay up to $800 per month to any active full-time member who becomes totally disabled and unable to work, as a result of a Non-Occupational disease or injury. The benefit will become effective after the member has been totally disabled for 60 consecutive days. **Only members using their own time will be eligible to receive this benefit. (Benefit will not be paid to anyone who is receiving time from the sick bank)** Said benefit will be paid during the disability up to a maximum disability period of two years.

The program benefit will not be provided for any period of disability caused as a result of self-inflicted wounds, alcoholic or drug abuse, job related illness or injury covered by workers compensation or any injury or illness commencing on full-time duty or training as a member of a U.S. Military Reserve Component.

The program will be closely monitored by the Board of Trustees. Any necessary adjustments will be made in order to continue the program for as long a period of time as possible on a sound financial basis. Should you have any questions regarding the Disability Program contact the Fund office.

ARE YOU ELIGIBLE?

Yes, if…

- You are promoted and become an active member of the New York State Court Clerks; or
- You are a current New York State Court Clerks Association Security Benefits Fund Member, and
- The State of New York provides contributions on your behalf to the New York State Court Clerks Security Benefits Fund.

WHO IS COVERED?

- You
- Your spouse
- Your domestic partner

*Your unmarried dependent children up to age 19 and up to age 25 if they are full-time students at accredited educational institutions.

*Dependent coverage is also extended to any unmarried child, regardtess of age, who is incapable of self-sustaining employment by reason of a mental or physical handicap and who becomes so prior to attainment of age 19 and who resides with and is wholly dependent on the covered member for financial support. You must submit proof of your dependent child's incapacity to the Fund Office 31 days after the date he/she attains the age at which his/her coverage would otherwise terminate, or within 31 days after you are notified of his/her termination of eligibility, whichever is later. Proof of the continued existence of such incapacity shall be furnished to the Fund Office from time to time as requested.

WHO IS AN ELIGIBLE DEPENDENT?

Your dependents are your lawful spouse, registered domestic partner and each unmarried child up to their 19th birthday and who are enrolled by you with the Fund as your dependent. "Child" is defined as a natural child, stepchild or adopted child, provided such child is dependent upon you for support and maintenance, and proof of such (e.g., adoption papers) is provided to the Fund Office. Coverage for a dependent child may be continued up to their 25th birthday if he or she is a full time student in an accredited educational institution, and proof of such (i.e., an original letter from Registrar's office with raised seal) is provided to the Fund Office within one month of the start of the current semester.

If your child reaches age 19 during a school vacation period, coverage will continue, as long as the child is enrolled in an accredited secondary or preparatory school or college or other accredited educational institution, provides written notification that the child plans to resume classes on a full-time basis at the end of the vacation period, and subsequently provides an original letter from the school's Registrar's office within one month of the start of the current semester.

WHAT HAPPENS IF THERE IS A CHANGE IN YOUR FAMILY STATUS?

It is important that you notify the Fund Office immediately of any change in your family status (to add dependents due to marriage, birth or adoption of a child, or to drop dependents due to death, divorce, legal separation, termination of domestic partnership or a child reaching an ineligible age or losing full-time student status and of any change of address. Failure to do so could result in loss or delay of benefits.

It is important and to your advantage that you keep the Fund up-to-date on your current status.

See Web Site for Participating Dentists

The New York State Court Clerks Security Benefits Fund provides a full range of Dental Benefits.

There are currently two dental plan options:

1. Self-Insured Plan (Reimbursement), with a participating provider option.

2. Dentcare Plan (HealthPlex)

Who is eligible?

Members and their eligible dependents, as defined on pages 2-3 of the section entitled "General Information" are covered. However, only eligible dependent children up to their 19th birthday are covered for orthodontic benefits, all orthodontic work must be completed by the child's 19th birthday.

Click Below for details on each plan.

How do Reimbursement Dental Expense Benefits work?

Reimbursement Dental Benefits provide scheduled reimbursement for expenses you incur for preventive, basic and major non-orthodontic dental services with no deductible required.

What does the plan pay?

Your Reimbursement Dental Benefits program pays a set amount for covered expenses you have for preventive, basic, and major dental services up to a maximum benefit of $2,750 per calendar year* for each covered person. A dental reimbursement schedule of dental procedures is provided upon request. * Effective January 2009

Who is eligible for the orthodontic benefit?

Eligible dependent children up to their 19th birthday, all orthodontic work must be completed by the child's 19th birthday.

How does the orthodontic benefit work?

Orthodontic services are reimbursed according to a fee schedule up to a lifetime maximum of $3,442. A period of orthodontic treatment starts on the first day your dependent incurs a covered expense for orthodontia and extends for a period of 24 consecutive months or less if the treatment is completed in less time. The orthodontic benefit is NOT included in the yearly dental maximum.

What are covered orthodontic expenses?

*The Initial work up: $142 *The diagnosis and insertion of the initial appliance; Once, up to $900*. *$100* per active monthly visit with a maximum of 24 consecutive visits. If your dependent misses a monthly visit, the Fund will not reimburse for that month but it will be counted toward the 24 consecutive visits. *Effective January 2009 Please note that the initial work up and the initial appliance are reimbursed only once during a period of orthodontic treatment.

Participating Providers are dental care providers who have agreed to provide covered dental procedures at No out-of-pocket expense to Fund members and their eligible dependents. We have selected participants in the dental care panel who have agreed to accept the Fund's fee schedule as PAYMENT IN FULL FOR COVERED SERVICES. In addition, we have sought out providers who have treated Fund members in the past. The Fund does not recommend the services of any particular provider.

Please remember that Fund members and their dependents are still subject to annual and lifetime coverage limits as specified in the dental plan description. The only time

that you will have to make a payment is for procedures that are not covered and for procedures performed after you have reached the annual maximum.

If, for any reason you encounter any irregularity or trouble with the services provided by a participating dentist, please contact our Dental Plan Administrator, Daniel H. Cook Associates, Inc., at (212) 505-5050 ext. 229.

Also, contact the Dental Plan Administrator if you are charged for any covered service.

DO NOT PAY ANY SUCH CHARGE.

A listing of all of the PPO dentists will be provided to you by the Fund Office upon request.

What is Pre-Authorization?

When a dentist's charges for a course of treatment will amount to $500 OR MORE, dental services must be authorized by the Fund before treatment is provided. Pre-authorization by the Fund's dental consultant is required for any proposed course of treatment in which a dentist's charges will amount to $500 or more. X-rays must be included with treatment plans submitted for pre-authorization.

Preauthorization by the Fund's dental consultant is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under the dental plan, nor is it a determination of the patient's eligibility or of the amount to be paid under the Fund's dental schedule.

The covered member's or eligible dependent's dentist is required to submit x-rays and a treatment plan to the Fund Office for review by the Fund's dental consultant no later than 30 days after the initial examination. A claim submitted for pre-authorization will be returned to the dentist indicating the preauthorization decision. Your dentist should contact you upon receipt of the claim form. The dentist may proceed to provide dental services as soon as the treatment plan has been authorized by the Fund. The Fund reserves the right to modify or deny payment of claims amounting to $500 or more which have not been approved by the Fund before the beginning of treatment.

How do you submit a claim?

Claim forms are available at the Fund office and/or your delegate. The forms themselves provide instructions concerning proper filing. Read these forms carefully and entirely. When you have a claim, you should promptly submit the completed claim form. Claims submitted 90 days after completion of dental services will be denied. It may become necessary to require additional proof or information concerning a particular claim, and therefore the Fund reserves the right to require such proof or information, including but not limited to any or all of the following:

- A dental chart showing work done before the treatment for which claim is made.
- X-rays, lab or hospital reports.
- Cast molds or other evidence of the dental condition or treatment.
- Post-treatment examination of the patient, at the Fund's expense, by a dentist it selects.

How are your benefits affected by the alternate benefit provision?

When more than one dental service would provide suitable treatment, your benefits will be based on the treatment determined by the Fund to be best suited to your condition by accepted standards of dental practice. If two services provide satisfactory results according to accepted standards of dental practice and one service is less expensive than the other, the Fund will reimburse up to the scheduled allowance for the less expensive treatment.

Exclusions

Benefits will not be paid for charges for:

- treatment from anyone other than a licensed dentist or physician, except routine cleaning of teeth and fluoride application which is performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician
- facings, veneers, or similar material placed on molar crowns or pontics
- services performed by a member of your or your spouse's immediate family, unless acceptable proof of payment is provided for those services
- services or supplies that are cosmetic in nature or directed toward a cosmetic end
- any service or supplies incurred, installed, or delivered before you or your dependent(s) become eligible for benefits from this Fund
- replacing a lost, missing or stolen prosthetic appliance
- a broken appointment
- any service that is not medically necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist
- services or supplies that do not meet accepted standards of dental practice including experimental or investigational services or supplies
- services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared
- any duplicate prosthetic appliance except as specifically provided
- completing claim forms

- oral hygiene, or dietary instruction or plaque control programs
- wiring or bonding teeth or crowns to act as a splint for any reason
- an injury arising from employment
- illness covered by Workers' Compensation
- services or supplies for which you are not required to pay
- appliances, restorations, or any procedure to alter vertical dimension for cosmetic purposes
- services or supplies not specifically listed under covered expenses

What is Dentcare(Healthplex)?

Dentcare (Healthplex), a DMO, is a prepaid, insured dental plan provided by Dentcare Delivery Systems. Under this plan, services are provided by Dentcare's network of dentists.

How do you enroll for the Dentcare Plan?

On an annual basis through the Fund Office. All members will be notified of the open enrollment period.

How do you select a dentist?

You must choose from a listing of Dentcare's affiliated providers. This selected dentist will service you and your eligible dependents. You must use an affiliated dentist in order to receive benefits under this plan. Should you or your eligible dependents go outside the Dentcare network, you will be fully responsible for any fees incurred.

What if you need a specialist?

Referrals to Dentcare screened specialists are handled only through your Dentcare affiliated provider either at his/her office or at conveniently located sites.

Do you have to change dentists if your present dentist is not a listed provider?

Yes. It is important to note that under this option, care provided by a non-participating dentist is NOT covered, unless arranged for by Dentcare.

Can we change our Dentcare dentist?

Yes, but only during an open enrollment period.

What happens in the case of an emergency?

In cases of emergency, you are covered for a maximum of two visits per member per contract year for services rendered by an affiliated provider. However, if you have had regular check-ups, or are undergoing treatment, the two visit limitation will be waived. If the emergency occurs out-of-area, or in the unlikely event you are unable to reach an affiliated provider, you will be reimbursed up to $25 per family member per contract year, upon presentation of bills for palliative care rendered by a non-participating dentist until treatment can be obtained from your participating provider. In the event you are unable to reach your own affiliated dentist, DENTCARE provides 24-hour emergency service operators. EMERGENCY REFERRAL 24 HOUR SERVICE (516) 794-3000 (800) 468-0600

Is there a claim review procedure?

Yes. Pre-certification by a Plan Dentist with the approval of the Dental Plan Director is necessary before any prosthetic services will be provided.

What are the exclusions and limitations?

Benefits shall not be provided for:

*Any dental services which were not rendered, prescribed, arranged, or approved by plan dentist except in cases arising out of a dental emergency. *General anesthesia. *Consultation by non-Plan Dentists unless specifically directed by Dentcare. *Any dental procedures which are undertaken primarily for cosmetic reasons. *Any service or appliance unless required in accordance with accepted standards of dental practice. *Prosthetic benefits are not covered where in the view of the Plan Dentist, sound restorations can be achieved by amalgam or alternative methods. *Replacements or substitutions of appliances supplied by Plan until five (5) years have elapsed. *Services or appliances used solely as an adjunct to periodontal care or for some cosmetic purposes. *Implants, sealants and other services not listed in the Schedule of Benefits. *More than two (2) oral examinations and oral prophylaxis (cleaning, scaling and polishing of teeth) per member per year. (Once every six months). *Orthodontia – Lost or Broken Appliance – There is a charge of $100.00 to replace appliance under the Comprehensive Option. *Broken Appointments – If specified by Plan Dentist for appointments not canceled 24 hours in advance, there is a $30.00 charge. *Dentures, crown, inlays, onlays, bridgework or other appliances or procedures altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost by abrasion or attrition, or treatment or a temporo-mandibular joint disturbance. *A new denture or bridgework if the existing denture or bridgework can be made serviceable. *Orthodontic services for eligible dependent children consisting of the necessary diagnosis and treatment of class 2 and 3 malocclusions which cause interference with normal function.

Vision Benefit

Who is covered?

Members and eligible dependents, (children to age 19 or up to age 25 if they are full-time students).

Benefits

The Fund offers many options: Vision Screening of Long Island, General Vision Services (GVS), and Vision Care Centers for all active members and their families.

GVS now includes General Vision, Select Cohen's Fashion Optical and Vision World Stores, S H Laufer, Sterling Optical, Eye Supply, Lens Lab Express and many popular optical outlets making them the largest 3rd party optical company in our area.

An optical voucher is required when obtaining your optical service benefits from the GVS network. Please call one of the listed optical locations in the GVS brochure for an appointment.

For member locations in Florida, Connecticut, New Jersey and Upstate New York, please call 1-800-VISION or visit at www.generalvision.com.

In addition to GVS, members may choose from either the Vision Screening network or the Vision Care Centers.

An optical voucher must be obtained from the union office before visiting either of these network providers.

To Review:

If you wish to go to any store in the GVS Provider Network No Voucher Is Needed

If you wish to go to the Vision Screening or Vision Care Centers A Voucher Is Required

Please note that any member may visit any other optical provider not in the above networks and that member will be reimbursed up to the newly increased maximum of $175* upon the submission of a receipt.

Death Benefit

Effective January 2007

Who is Covered?

All active Court Clerks and their eligible dependents enrolled in the fund.

Amount of the Death Benefit?

The Security Benefits Fund provides a:

-$25,000 death benefit for all active members; -$10,000 death benefit for an active member's spouse

-$5,000 death benefit for each eligible dependent child of an active member.
In the event of a death, the member's death benefit payment will be made to the beneficiary listed on your Security Benefits Fund Enrollment Card. A Death Benefit for an active member's spouse or eligible dependent children will be paid directly to the active member. If you have not designated a beneficiary, the death benefit will be paid to the following successive preference beneficiary;

1. Spouse
2. Children, in equal shares
3. Parents, in equal shares
4. Brothers and sisters, in equal shares
5. The estate of the deceased.

If the member wished to change his/her beneficiary designation, he/she can do so by requesting a change of beneficiary form from the Fund Office.

Maternity Benefit

The Fund will reimburse a covered member in the amount of *$1,000 per birth. To apply for this benefit, a copy of the birth certificate or a statement from the hospital, must be filed with the Fund Office.

Adoption Benefit

The Fund will reimburse a member *$1,000 per family for costs associated with the adoption of a child, providing adopted child has no previous family relationship to either parent. Adoption must be through a licensed adoption agency accredited in the United States. Only one claim and one payment of *$1,000 per annum will be paid.

Hearing Aid Benefit

This benefit provides reimbursement to a member and eligible dependents of up to $400 for each ear for a hearing aid device prescribed by a physician or audiologist. This does not include batteries or repair, only the hearing aid itself. The benefit will be available every four years and will be offset by any reimbursement from any insurance plan. A hearing aid claim form is available from the Fund Administrator.

Inner Imaging Full Body Scan

The Trustees of the Security Benefit Fund have reached an agreement with Inner Imaging and the Continuum Heart Institute at Beth Israel Medical Center. Members and Spouses may choose to receive the (EBT Body Scan) through Inner Imaging and the Continuum Heart Institute at Beth Israel Medical Center.

Beth Israel Medical Center is open Monday-Friday 7:30am to 6:30 pm, with some Saturday hours available. The phone number is 212-991-5445. **The exam cost for Member and/or Spouse will be covered for the Heart, Lung scan and also for the Heart, Lung, Abdomen, and Pelvis screening**. The balance will be paid by the Court Clerk Benefit Fund. Non-Union members have paid upwards of $800 – $1,200 for this procedure.

This benefit will be provided once every five years and will count toward your eligibility for the Manhattan Internal Medicine Associates, P.C. for the year that it is utilized.

Annual Physical Examination

The Annual Physical Examination is provided by Manhattan Internal Medicine Associates, P.C. The member and spouse are covered at **no**cost. No voucher is necessary, just call and make the appointment. Visit the link section for contact information. Your Health Care ID is necessary, the association covers the co-payment.

HeartScan Services

The Heartscan Services screening benefit is free and available to active and retired members and their spouses. **Heartscan Services provides five preventive screens that focus on early detection for Heart disease (echocardiogram-), stroke (carotid doppler), thyroid cancer (nodules), vascular disease (ABI) and abdominal aortic aneurysm (AAA).** The preventive screening takes about 45 minutes, is non-invasive and is available to our active and retired members and spouses every year.

For more information visit: www.heartscanservices.com

Call 1-866-518-1112 to schedule your appointment

View pamphlet

Supplemental Hospital Benefit

When a member, spouse or domestic partner is confined in a hospital, the Fund will provide an allowance of **$100 per overnight stay up to a maximum of **$1,500 per year. This amount is in addition to any allowance provided by Blue Cross.

The Fund will reimburse on a per stay basis. The maximum allowable benefit is**$1,500 per year. To file a claim for this Supplemental Hospital-Medical Benefit the member should submit to Cook Associates, a copy of the hospital bill which will reflect the name of the patient and the period of confinement. This benefit does not cover a maternity stay at the hospital. The claim must be filed within 90 days of the date of release from the hospital.

*Increase Effective January 1, 2007
** Increase Effective April 1, 2007

Coordination of Benefits

What is Coordination of Benefits?

When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all group plans will not exceed 100% of the total amount charged. If you and your spouse are both members of the New York State Court Clerks Security Benefits Fund and eligible for benefits, your benefit payments will also be coordinated not to exceed 100% of the total amount charged.

How does Coordination of Benefits work?

If you are a covered member of the Fund and are eligible for benefits from another group plan:

- Submit your claim to the Fund office.
- After you have received payment from the Fund, you may submit a claim for the unpaid balance to the other group plan under which you are eligible for benefits.
- You will receive any additional benefits, which may be due for this claim under the second plan.
- The total amount you receive for the claim from this Fund and from any other group plan cannot exceed 100% of the total amount charged.

If your spouse has a claim and is eligible for benefits under another group plan:

- Your spouse must submit a claim to his or her plan first.
- After the claim is paid by your spouse's plan, a claim for the unpaid balance may be submitted to this Fund along with an explanation of benefits received from the other plan.
- Any additional benefits, which may be due for this claim, will be paid by this Fund.
- The total amount paid for the claim from any group plan under which your spouse is eligible and from this Fund cannot exceed 100% of the total amount charged.

If a claim is submitted for a child when one parent is a covered member of the Fund and the other parent is a covered member of another plan:

- Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in the calendar year.
- After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan.
- The payment you receive for the claim from both plans cannot exceed 100% of the total amount charged.

If the claim is submitted for a child whose parents are ddorced when one parent is a covered member of the Fund and the other parent is a covered member of another plan:

If the parent with custody has not remarried,

- Submit the claim to the plan which covers the parent with custody first.
- After the claim has been paid by the first plan then it may be submitted to the second plan along with an explanation of benefits from the first plan.
-

If the parent with custody has remarried,

- Submit the claim to the plan which covers the parent with custody first.
- Submit the claim to the plan which covers the step-parent second.
- Submit the claim to the plan covers the parent without custody last.
  If there is a court order which establishes financial responsibility for the medical, dental or other health care expenses of the child, submit the claim to the plan which covers the parent with the court ordered responsibility first. A copy of such court order must be submitted with your claim.

Amendment or Termination of Benefits

The benefits provided by this Fund may, from time to time, be changed, modified, augmented, or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust indenture, which established the Fund and governs its operations.

Your coverage and your dependent's coverage will stop on the earliest of the following dates:

- When the Fund is terminated
- When you are no longer eligible
- When there is a non-payment of the direct payments
- When the State of New York or the quasi-public Agency, Authority, Board or Corporation ceases to make contributions on your behalf to the Fund
- Your dependents' coverage will also terminate when they are no longer your eligible dependents.

Active member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits either before or after his or her retirement. The Trustees may expand, modify or cancel the benefits for active members; change eligibility requirements or the amount of the direct payments; and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.

Third-Party Reimbursement/Subrogation

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled—to the extent it pays out benefits—to reimbursement from the covered member or dependent from any recovery obtained. Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim for recovery against the third party.

Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

1. To reimburse the Fund, to the extent of benefits paid by it, out of any money recovered from such third party, whether by judgment, settlement or otherwise;
2. To provide the Fund with an assignment of proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the fund on seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services;
3. To take all reasonable steps to affect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

Appeal Procedure

All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject to review only by the Trustees. A covered member, eligible dependent or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees, New York State Court Clerks Association, 170 Duane Street, New York, New York 10013. In addition, the appellant shall provide any documentation to support his or her claim. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

Additional Information

The New York State Court Clerks Association Security Benefits Fund is administered by the Board of Trustees which has been designated as the agent for the service of legal process. All contributions to the plan are made by the State of New York in accordance with their collective bargaining agreement with the New York State Court Clerks Association.

The Collective Bargaining Agreement requires contributions to the Fund at fixed rates per year worked. Benefits are provided from the Fund's asset which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies.

All the types of benefits provided by the Fund are set forth in the Outline of Benefits of this booklet. The complete terms of the insured benefits are set forth in the group insurance policies or contracts with the organizations. The complete terms of the self-insured benefits are set forth in the Fund Rules and Regulations.

As someone who is eligible for benefits from this Fund you are no doubt aware of the fact that the benefits are paid in accordance with plan provisions out of a trust fund which is used solely for that purpose. If you have any questions or problems as to benefit payments, you have the right to get answers from the Trustees who administer the Fund. Nothing in this statement is meant to interpret or extend or change in any way, the provisions expressed in the Fund or insurance policies. The Trustees reserve the right to amend, modify or discontinue all or part of the Fund whenever, in their judgment, conditions are warrant.