Dear Retired Member: 

Jan 2017

The Trustees are pleased to provide you with this Comprehensive Benefits Booklet describing the benefits that are available to you as a Retired Member of the Assistant Deputy Wardens/Deputy Wardens Security Benefits Fund. The programs are designed to provide you with additional benefits that are not provided by your basic City coverage.

The Security Benefits Fund is funded entirely by the contributions, which are made by the City as a result of the collective bargaining agreements between the Assistant Deputy Wardens/Deputy Wardens Association (ADWDWA) and the City of New York. You are not required to make any payment toward the cost of the benefits program (Some Co-pays may be required). In a fiscally prudent manner, the Trustees of the Security Benefits Fund continually monitor what benefits can be improved and what new benefits can be provided.

We have tried to present all the information about your retired coverage in plain non-technical language. Periodically you will receive updated pages to the booklet to keep it current with benefit changes. Master claim forms are also included in this booklet for your reproduction needs. Please retain these forms in your booklets and make photocopies when necessary.

To the extent that this booklet describes an insured benefit (e.g., Life Insurance), the group insurance contract specifies the exact benefits provided and the language of the insurance contract will govern in the event of inconsistency between it and the language of this booklet.

We suggest that you read this booklet carefully and keep it available so that you may refer to it in the future.

Fraternally yours

Faisal Zouhbi
President
ADW/DWA
# TABLE OF CONTENTS

## GENERAL INFORMATION
- Eligibility .......................................................... 2 - 4
- Extension of Benefit .............................................. 4
- Amendment and Termination of Benefits ............... 4 - 5
- Third-Party Reimbursement/Subrogation ................ 5 - 6
- Right to Appeal .................................................... 6
- Right to Recoup Payments Made in Error .............. 7
- Coordination of Benefits ..................................... 8 - 9
- Continuation of Benefits (COBRA) ......................... 10 - 14
- Notice of Privacy Practice .................................. 15

## DENTAL BENEFITS PROGRAM
- Dental Plan Comparison ...................................... 16 - 17
- Dentcare/Healthplex Option ................................. 18 - 22
- ASO/SIDS Option ................................................. 23 - 37

## VISION CARE EXPENSE BENEFITS
- Schedule of Allowances ....................................... 38
- Exclusions .......................................................... 39
- How to File a Claim .............................................. 39
- Participating Provider Option ............................... 40 – 43

## OTHER BENEFITS
- New Dependent Benefit ....................................... 44
- Hearing Aid Benefit ............................................ 45
- Health & Wellness Benefit ................................... 46
- Survivor Continuation Benefit .............................. 47
- Retired Member Advocacy Service ......................... 48 - 49
- Inner Imaging/Body Scan Benefit ......................... 50 - 52
- Heart Scan Services ............................................. 53
- Funeral Benefit .................................................... 54

## TERM LIFE INSURANCE
- ........................................................................... 55 - 56

## SAMPLE CLAIM FORMS
- ............................................................................

## PARTICIPATING PROVIDER DIRECTORIES
- www.asonet.com
- www.healthplex.com
Each section of this booklet contains detailed claim filing instructions. Original claim forms are enclosed. Please retain these forms and photocopy when necessary. For claim/benefit inquiries and Participating Provider Organization questions, please call or write to:

Administrative Services Only, Inc.
Self-Insured Dental Services, Dept. 66
Post Office Box 9005
Lynbrook, NY 11563-9005

Telephone:  (516) 396-5500
            (718) 204-7172
            (800) 537-1238 (outside New York State)

For questions concerning the Annuity Fund call:

(516) 396-5520

For questions concerning the Life Insurance Benefit contact:

Amalgamated Life Insurance Co.
333 Westchester Avenue
White Plains, NY 10604
(914) 364-5550

Contact: Debbie Internicola
(646) 522-0370

Please be sure to identify yourself as a Retired Member of the ADWDWA Security Benefits Fund to avoid any delay and to make sure that the appropriate information is provided to you.
ELIGIBILITY

ELIGIBLE RETIRED MEMBERS *

All retired Assistant Deputy Wardens / Assistant Deputy Superintendents, Deputy Wardens / Deputy Superintendents and Deputy Wardens-in-Command, for whom the Security Benefits Fund receives a contribution under the Collective Bargaining Agreements with the City of New York are eligible for these benefits.

* Retired prior to January 1, 1979;
* Deputy Wardens and Deputy Wardens-in-Command retired or retiring after June 28, 1996

ELIGIBLE DEPENDENTS:

Your spouse, unless legally separated.

Your domestic partner, defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation (to the City of New York Health Benefits Program) of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner’s will; assignment of a durable power of attorney or health care power of attorney; or other such proof as is determined by the City of New York to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and,
- has signed jointly with you a notarized affidavit which can be made available to the Fund upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:
has signed a Domestic Partner affidavit or declaration with any other person within six months prior to designating each other as Domestic Partners hereunder;

is currently legally married to another person; or,

has any other Domestic Partner, spouse, or spouse equivalent of the same or opposite sex.

Finally, you and your Domestic Partner must have registered as Domestic Partners, if you reside in a State that provides for such registration. Your Domestic Partner is covered for Fund benefits if he/she is approved as an eligible Domestic Partner under the City of New York’s Health Benefits Program (in this section referred to as the “Basic Plan”).

A qualified Domestic Partner becomes eligible on the date he or she is approved for coverage by the Basic Plan, provided that notification has been sent to the Fund within 31 days of the date the Retired Member receives Basic Plan approval of Domestic Partner coverage. The documentation necessary to submit to the Fund is a copy of the Basic Plan’s letter detailing the approval of the Domestic Partner’s coverage. If a Domestic Partner is confined to a hospital on the day coverage would begin, coverage will not begin until the date of hospital discharge.

**Your unmarried dependent children** age 14 days through 26 years. With the exception of Dependent Term Life Insurance and Orthodontic Benefits, unmarried dependent children over age 19 but less than age 26 are also eligible for Security Fund Benefits, provided that they are chiefly dependent upon you, the Retired Member, for support and maintenance.

**Stepchildren and legally adopted children** may be eligible for benefits provided that they are chiefly dependent upon you, the Retired Member, for support and maintenance and are enrolled with the Fund, by you, when you enroll or when they initially become your dependents.

**A child who is physically or mentally incapable of self-support** and is an eligible dependent under the Fund’s benefits plan upon attaining age 26 may be continued under the Plan while remaining so incapacitated and unmarried, subject to your own coverage remaining in effect. To continue a child under this provision, proof of incapacity must be received by the Security Benefits Fund within 31 days after coverage would otherwise terminate (due to the child attaining the age of 26). Additional proof will be required periodically.

No one will be eligible as a dependent while covered as a Member or while on Active Military Service.

IN ORDER FOR YOUR ELIGIBLE DEPENDENTS TO BE COVERED BY THE ADWDWA SECURITY BENEFITS FUND, YOU MUST SUBMIT COPIES OF THE
FOLLOWING APPLICABLE DOCUMENTS WITHIN THIRTY-ONE (31) DAYS OF THE EVENT:

1. Marriage Certificate;
2. Birth Certificate;
3. Domestic Partner Registration Certificate;
4. Legal Adoption papers;
5. Legal Guardianship papers; and,
6. For physically or mentally disabled, dependent children under age 26: a letter from a physician stating the physical or mental incapacity, onset, and expected duration of disability.

See specific dependent eligibility requirements for Dependent Life Insurance.

EXTENSION OF BENEFITS

For Eligible Dependents Upon the Death of a Retired Member

If a Retired Member dies while still covered under the Fund, an extension of twelve months eligibility from the Retired Member’s date of death will be provided for the Retired Member’s eligible dependents for the following benefits:

- Dental
- Vision

AMENDMENT AND 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 Agreement which established the Fund and governs its operations.
Your coverage and your dependents’ coverage will stop on the earliest of the following dates:

- When the Fund is terminated.
- When you are no longer eligible.
- When there is non-payment of the direct pay premiums.
- When the Employer ceases to make contributions on your behalf to the Fund.

Your dependents’ coverage will also terminate when they are no longer eligible dependents.

Retired 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. The Trustees may expand, modify or cancel the benefits for Retired Members and dependents; change eligibility requirements or the amount of the self-pay premiums; and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retired Member or any other person.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered Retired 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 Retired Member or dependent from any recovery obtained from the responsible third party (including Workers’ Compensation cases). Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered Retired 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 recovery against the third party.

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

A. To reimburse the Fund, to the extent of benefits paid to it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise;

B. 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 in 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; and,
C. To take all reasonable steps to effect 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.

**BENEFITS PAYABLE ON BEHALF OF DECEASED RETIRED MEMBER**

With respect to any benefits payable to a deceased Retired Member upon the date of death, or with respect to death benefits payable by virtue of the death of the Retired Member where the Retired Member’s designated beneficiary has predeceased the Retired Member and a successor has not been designated, or where the Retired Member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered Retired Member's:

A. Surviving spouse;

B. If no surviving spouse, to the surviving children equally; or,

C. If no surviving children, to the covered Retired Member's estate.

**RIGHT TO APPEAL**

The benefits provided by this Fund may be changed 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 Agreement which established and governs the Fund operations.

All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject only to review by the Board of Trustees. A Retired Member or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees:

ADWDWA SECURITY BENEFITS FUND  
c/o Administrative Services Only, Inc.  
Department 66  
Post Office Box 9005  
Lynbrook, NY 11563

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.
RIGHT TO RECOUP BENEFIT PAYMENTS MADE IN ERROR OR TO SUSPEND BENEFITS COVERAGE

The Fund has the right to recoup overpayments that were caused by an error in the processing of a claim, or, if additional information comes to the attention of the Fund after the claim has been paid. Furthermore, the Fund has the right to suspend one or more benefits if you have received overpayments or have in any way abused the Fund's benefit program.

If the Fund finds it has overpaid you, or an otherwise ineligible dependent, for a particular benefit, it has the right to recoup the excess amount from you. The Fund may bill you for overpayments made, and/or, it may also reduce future benefit payments to offset the overpaid amounts or it may suspend your benefits until the overpayment is recouped.
In the event that a person covered by the ADWDWA SECURITY BENEFITS FUND is covered under another group plan, there will be "coordination of benefits" regarding reimbursement by this Fund. This coordination will apply in the event that an expense is incurred for a covered item under this Fund that is also covered under the other plan.

A determination will be made as to which plan is “primary”, or the first plan to pay, and which plan is the “secondary” payer.

The method to determine which plan is primary is based on the following rules:

1. If the claimant is a covered Retired Member of the Security Benefits Fund, then the Security Benefits Fund will pay benefits first, while a plan covering a Retired Member as a dependent will pay second.

2. If a dependent child is covered by plans of both parents, the benefits of the plan which covers the child of the parent whose date of birth (month and day only, excluding year) occurs earlier in the calendar year, will be determined to be the primary payer. The benefits of the plan which covers the child of the parent whose date of birth (excluding the year) occurs later in the calendar year, will be determined the secondary payer.

   If a plan containing this “Birthday Rule” is coordinated with a plan which contains a gender-based rule, and, as a result the plans do not agree on the order of benefits payment, the gender-based rule plan will determine the order.

3. When parents are divorced or separated, the order of benefit payment for a dependent child is:

   (a) The plan of the parent with custody pays first and the plan of the parent without custody pays second.

   (b) If the parent with custody has remarried the order is:

      (1) The plan of the parent with custody pays first.

      (2) Next, the plan of the step-parent pays.

      (3) The plan of the parent without custody pays last.

If there is a court decree which states that one parent is responsible for the child’s health care expenses, the plan of that parent will pay first. That court decree will supersede any order stated above.
4. If a person is covered under more than one plan, the plan that he or she was under for the longer time period pays first, as if there were no other plan. If this Fund is the secondary plan, it will coordinate the benefits with the primary plan so that no greater than 100% of the allowable expense will be paid.

If you or your family Retired Members are eligible to receive benefits under another group plan in addition to this one, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the allowable expenses incurred will be paid jointly by the plans. In order to obtain all of the benefits available, you and your family Retired Members should file claims under each plan. Retired Members should file with the primary plan first and then the secondary plan.

Be certain to include a copy of the payment voucher ("Explanation of Benefits" Form) from the primary plan when filing a claim with the secondary plan.
A. Statutory Continuation of Coverage

1. COBRA CONTINUATION OF COVERAGE

Federal law requires that most group health plans (including the Assistant Deputy Wardens/Deputy Wardens Association Security Benefits Fund, the “Fund”) give employees (known as “Retired Members” in the case of the Fund) and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan (in this case, the Fund’s plan of benefits under which the individual was covered). Depending on the type of qualifying event, “qualified beneficiaries” can include the employee/Retired Member (or retired employee/Retired Member) covered under the Fund’s plan, the covered employee's/Retired Member’s spouse/domestic partner, and the dependent children of the covered employee/Retired Member.

Continuation coverage is the same coverage that the Fund’s plan gives to other Retired Members or eligible dependents who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other Retired Members or eligible dependents covered under the Fund’s plan.

2. How long will continuation coverage last?

In the case of a loss of Fund coverage due to end of employment or reduction in hours of employment with the New York City Department of Correction, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to a Retired Member’s / employee’s death, divorce or legal separation, the Retired Member’s / employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Fund’s plan, coverage may be continued for up to a total of 36 months.
When the qualifying event is the end of employment or reduction of the Retired Member's/employee's hours of employment with the New York City Department of Correction, and the Retired Member / employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Retired Member/employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium for continuation coverage is not paid to the Fund in full and on time,
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or,
- The Fund ceases to provide any health related benefits to its Retired Members.

Continuation coverage may also be terminated for any reason that the Fund would terminate the coverage of a Retired Member who is not receiving continuation coverage.

3. **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage from the Fund, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Fund's Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.
5. **Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide the Fund's Coordinator with a copy of an SSA disability determination letter within 60 days of the determination in order to extend the period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Fund's Administrator of that fact within 30 days after SSA's determination.

6. **Second Qualifying Event**

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Retired Member/employee, divorce or separation from the covered Retired Member/employee, the covered Retired Member's/employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund’s plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Fund's plan if the first qualifying event had not occurred. You must notify the Fund's Administrator within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

7. **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the Fund's Continuation Coverage Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Retired Member's / employee's spouse may elect continuation coverage even if the Retired Member/employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The Retired Member/employee or the Retired Member's/employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.
In considering whether to elect continuation coverage, you should take into account that a failure to continue your Fund health-related benefits coverage may affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your Fund’s health-related benefits coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

8. How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the Fund for coverage of a similarly situated Fund Retired Member or eligible dependent who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

B. For more information

If you have any questions concerning COBRA continuation coverage, you should contact the Fund’s Third Party Administrator,

Administrative Services Only, Dept. 66, P.O. Box 9005 Lynbrook, NY 11563-9005,

Telephone: 516-396-5500 or 718-204-7172.
For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

C. Keep Your Plan Informed of Address Changes

In order to protect your and your family’s rights, you should keep the Fund informed of any changes in your address and the addresses of family Retired Members. You should also keep a copy, for your records, of any notices you send to the Fund’s Coordinator.
The Health Insurance Portability and Accountability Act, ("HIPAA"), a federal law, requires the ADWDWA Security Benefits Fund ("the Fund") to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund’s privacy notice, which was distributed to all current Retired Members of the Fund prior to April 14, 2004 and is distributed to all new Retired Members upon enrollment, a copy of which is available from the Fund office.

The Fund will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe the Fund’s privacy rules. In particular, the Fund will not, without authorization, use or discloses protected health information for employment-related actions and decisions.
**CHOICE OF TWO PLANS:** You and your eligible dependents are entitled to dental coverage. There are two dental plans offered:

1. Dentcare/HealthPLEX (Capitation Plan)

2. Self-Insured Dental Services (Scheduled Plan)

The Retired Member must choose a plan upon initial enrollment in the Plan. The Dental Option that the Retired Member selects is the Dental Plan under which all eligible dependents will be covered.

If you wish to change plans, note that Plan choice changes are permitted once in a 12-month period. To change plans, contact the Plan Administrator. You will be sent a complete enrollment kit including descriptions of the plans, along with an Enrollment Form that must be completed and returned to the Plan Administrator. Plan changes will become effective on the first day of the month after the Plan Administrator receives your Enrollment Form if the form is received after the 15th of the month; and on the first day of that month for Enrollment Forms received before the 15th. For example, if your change request form is received on June 15th, you will be enrolled in your new plan effective July 1st, or if your Enrollment Form is received on June 13th you will be enrolled in your new Plan effective June 1st.

The following pages outline the plans and include relevant information, including plan comparisons of both dental options.

Please keep in mind that Dentcare/HealthPLEX is a Capitation Plan. Providers are paid monthly whether or not their services are utilized. If you seldom use their services, we highly recommend enrollment in Self-Insured Dental Services, as it will result in a savings to our Fund that can be used to enhance benefits at a future date for all Participants.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Dentcare / HealthPLEX Capitation Plan*</th>
<th>ASO/SIDS PPO Participating Providers</th>
<th>ASO/SIDS NON-PPO Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam/Cleaning</td>
<td>1 Every 6 Months</td>
<td>3 /Calendar Year</td>
<td>3/Calendar Year</td>
</tr>
<tr>
<td>Fluoride</td>
<td>1 Every 6 Months</td>
<td>2/Calendar Year</td>
<td>2/Calendar Year</td>
</tr>
<tr>
<td>Full Mouth X-Ray Bitewing X-Ray</td>
<td>1 Series/36 Months</td>
<td>$75 per year MAX</td>
<td>$75 per year MAX</td>
</tr>
<tr>
<td>Crowns/ Limitations</td>
<td>Once/5 Years</td>
<td>No Copayment Once/5 Years</td>
<td>As per Schedule Once/5 Years</td>
</tr>
<tr>
<td>SERVICE</td>
<td>Dentcare / HealthPLEX Capitation Plan*</td>
<td>ASO/SIDS PPO Participating Providers</td>
<td>ASO/SIDS NON-PPO Non-Participating Providers</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Fixed Bridges/Limitations</td>
<td>Once/5 Years</td>
<td>No Copayment Once/5Years</td>
<td>As per Schedule Once/5 Years</td>
</tr>
<tr>
<td>Partial Dentures/Limitations</td>
<td>No Copayment</td>
<td>No Copayment Once/5 Years</td>
<td>As per Schedule Once/5 Years</td>
</tr>
<tr>
<td>Full Dentures/Limitations</td>
<td>No Copayment</td>
<td>No Copayment Once/5 Years</td>
<td>As per Schedule Once/5 Years</td>
</tr>
<tr>
<td>Orthodontia Active Treatment</td>
<td>Maximum 24 Months Dependent Children Only</td>
<td>Maximum 24 Months $3600 lifetime MAX for dependents under age 19</td>
<td>Maximum 24 Months $3600 lifetime MAX for dependents under age 19</td>
</tr>
<tr>
<td>Lost or Broken Orthodontic Appliance</td>
<td>Not Covered</td>
<td>Non-Covered Service</td>
<td>Non-Covered Service</td>
</tr>
<tr>
<td>Prosthetic Repair</td>
<td>No Charge</td>
<td>No Co-Pay</td>
<td>Per Schedule</td>
</tr>
<tr>
<td>General Anesthesia/IV Sedation</td>
<td>Non-Covered Service</td>
<td>No Co-Pay</td>
<td>Per Schedule</td>
</tr>
<tr>
<td>Broken Appointment</td>
<td>$30 Charge if Not Cancelled with 24-Hour Notice</td>
<td>According to Individual Office Policy</td>
<td>According to Individual Office Policy</td>
</tr>
<tr>
<td>Office Hours</td>
<td>Subject to Dentist Schedule</td>
<td>Subject to Dentist Schedule</td>
<td>Subject to Dentist Schedule</td>
</tr>
<tr>
<td>Office Selection</td>
<td>You Must Choose One Dental Office</td>
<td>Select from a Participating List</td>
<td>Freedom of Choice</td>
</tr>
<tr>
<td>Out of Area Emergency</td>
<td>Up to $25 per Individual per Year</td>
<td>Plan Pays According to Schedule</td>
<td>Plan Pays According to Schedule</td>
</tr>
<tr>
<td>Specialists</td>
<td>Usually Referred to Another Office</td>
<td>Refer to PPO Listing</td>
<td>Plan Pays According to Schedule</td>
</tr>
<tr>
<td>Implants</td>
<td>Not Covered</td>
<td>No Co-pay</td>
<td>Per Schedule</td>
</tr>
</tbody>
</table>
DENTCARE/HEALTHPLEX OPTION

If you select Dentcare/HealthPLEX as your dental option, you and your eligible dependents must choose a Dentcare/HealthPLEX Dentist or Dental Site and must use only the Dentist or Dental Site selected.

DENTCARE/HEALTHPLEX is a prepaid program of preventive dentistry offered by Dentcare Delivery Systems, Inc., a not-for-profit dental insurance company licensed by the New York State Insurance Department.

Under this managed care program, you select one dentist for you and your family from the Affiliated Provider List. This dentist will provide you with all necessary care, referring to a wide range of specialists should it become necessary. If you wish to change your dentist you must submit a revised Enrollment Form to Dentcare/HealthPLEX. If the change is received prior to the 15th of the month, it will go into effect the first of that month. If the change is received after the 15th of the month, it will go into effect on the first day of the following month. We request that you wait until you receive your eligibility card (except of course in case of emergency) before making appointments. It is important to note that under this option, care provided by a non-participating dentist is NOT covered, unless arranged for by DENTCARE/HEALTHPLEX. There are no out-of-pocket expenses for Basic or Preventive dental services. If you select this Dental Plan Option, you must remain in this plan for a minimum of one year.

In cases of emergency, you are covered for a maximum of two visits per individual 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 Retired 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 / HEALTHPLEX provides 24-hour emergency service operators.

EMERGENCY REFERRAL
24 HOUR SERVICE
(800) 468-0600

No dental form is required under the Dentcare/HealthPLEX Plan Option.
### DENTCARE/HEALTHPLEX SCHEDULE

#### DIAGNOSTIC & PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Examination</td>
<td>No Charge</td>
</tr>
<tr>
<td>Full mouth x-ray</td>
<td>No Charge</td>
</tr>
<tr>
<td>Single Films (periapical or bitewing)</td>
<td>No Charge</td>
</tr>
<tr>
<td>Bitewing Series</td>
<td>No Charge</td>
</tr>
<tr>
<td>Cleaning of Teeth (prophylaxis &amp; polishing)</td>
<td>No Charge</td>
</tr>
<tr>
<td>Fluoride Treatment</td>
<td>No Charge</td>
</tr>
<tr>
<td>Specialty Consultation</td>
<td>No Charge</td>
</tr>
<tr>
<td>Treatment in case of dental emergency</td>
<td>No Charge</td>
</tr>
<tr>
<td>Broken Appointment without 24-hour notice</td>
<td>$30</td>
</tr>
</tbody>
</table>

#### RESTORATIVE DENTISTRY

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silver amalgam, one surface</td>
<td>No Charge</td>
</tr>
<tr>
<td>Silver amalgam, two surfaces</td>
<td>No Charge</td>
</tr>
<tr>
<td>Silver amalgam, three surfaces or more</td>
<td>No Charge</td>
</tr>
<tr>
<td>Composite filling, one surface</td>
<td>No Charge</td>
</tr>
<tr>
<td>Composite filling, two surfaces</td>
<td>No Charge</td>
</tr>
<tr>
<td>Composite filling, three surfaces or more</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

#### ORAL SURGERY

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine extractions — per tooth</td>
<td>No Charge</td>
</tr>
<tr>
<td>Surgical extractions</td>
<td>No Charge</td>
</tr>
<tr>
<td>Soft tissue impactions</td>
<td>No Charge</td>
</tr>
<tr>
<td>Bony impaction</td>
<td>No Charge</td>
</tr>
<tr>
<td>Alveolectomy, per quadrant</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

#### ROOT CANAL THERAPY

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulp Capping, Direct</td>
<td>No Charge</td>
</tr>
<tr>
<td>Pulpotomy</td>
<td>No Charge</td>
</tr>
<tr>
<td>Root Therapy — Anterior</td>
<td>No Charge</td>
</tr>
<tr>
<td>Root Therapy — Bicuspid</td>
<td>No Charge</td>
</tr>
<tr>
<td>Root Therapy — Molar</td>
<td>No Charge</td>
</tr>
<tr>
<td>Apicoectomy</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

#### PERIODONTICS

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling of teeth, per quad</td>
<td>No Charge</td>
</tr>
<tr>
<td>Gingivectomy, per quad</td>
<td>No Charge</td>
</tr>
<tr>
<td>Osseous surgery, per quad</td>
<td>No Charge</td>
</tr>
</tbody>
</table>
**PROSTHETICS — CROWNS**
Acrylic with metal crown ........................................... No Charge
Porcelain crown .................................................... No Charge
Porcelain with metal crown ..................................... No Charge
Stainless steel crown ............................................ No Charge
Post ........................................................................ No Charge
Recementation, per crown ....................................... No Charge

**PROSTHETICS — FIXED BRIDGES**
Acrylic w/metal bridge crown or pontic ..................... No Charge
Porcelain w/metal bridge crown or pontic, each unit . No Charge
Recementation, bridge .......................................... No Charge

**PROSTHETICS — REMOVABLE**
Full upper or lower denture, w/adjustments .............. No Charge
Partial upper or lower denture, cast base ................. No Charge
Denture adjustments ............................................ No Charge
Broken Body of Denture ........................................ No Charge
Replacement of Broken/Missing Teeth ...................... No Charge

**ORTHODONTIA — (Dependent Children Only)**
Maximum case fee — 24 months ............................. No Charge
DENTCARE/HEALTHPLEX

The following limitations apply:

- Oral exams, bitewing x-rays, prophylaxis, scalings and fluoride treatments — Once every 6 months.
- Full mouth and panoramic x-rays — Once every 36 months.
- Crowns, bridges, dentures & periodontal surgery — Once every 60 months.
- Orthodontic treatment of Class II/Class III malocclusions — One 24-month case.

Exclusions and Limitations:

A. Any dental services which were not rendered or approved by a participating dentist except in cases of out-of-area dental emergency.

B. A service not furnished by a Dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist.

C. Treatment of a disease, defect, or injury covered by a major medical plan, Workmen’s Compensation Law, occupational disease law, or similar legislation.

D. General Anesthesia, I.V. Sedation, analgesia and any service rendered in a hospital environment.

E. Any dental procedures which are undertaken primarily for cosmetic reasons or dental care to treat accidental injuries, congenital or developmental malformations.

F. Restorations, crowns or fixed prosthetics when acceptable results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the Plan will allow for the least costly alternative and the patient is responsible for all additional fees charged by the dentist.

G. Services which were started prior to the person becoming covered under this plan.
H. Implants, grafts, precision attachments or other personalized restorations or specialized techniques.

I. Replacement of any existing crown, bridge or denture which can be made serviceable according to common dental standards.

J. Procedures, appliances or restorations whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth, or restore occlusion.

K. Treatment of unmanageable children and/or unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents of the patient.

L. Services not listed in the Schedule of Benefits are not covered.

Alternate Benefit Provision: The contract requires that if alternate methods of treatment exist, payment will not be made for treatment carrying the greater fee, unless that treatment is the only adequate treatment. If you elect to proceed with the more costly procedure you will be responsible for payment up to the doctor’s regular fee for the procedure not the retiree payment according to the DENTCARE/HEALTHPLEX Schedule.
**ASO/SIDS OPTION**

The dental expense benefits will be paid for covered services and supplies as the result of non-occupational dental disease or defect in connection with a dental procedure furnished to you by a dentist while you are covered. You may choose any duly licensed dentist or dental surgeon.

**ELIGIBILITY**

Retired Members of the ASSISTANT DEPUTY WARDENS/DEPUTY WARDENS ASSOCIATION, for whom the ADWDWA Security Benefits Fund receives a contribution under the Collective Bargaining Agreement with the City of New York, are eligible for these benefits.

**Eligible Dependents** — Includes the lawful spouse/domestic partner and each dependent child from birth until the age of 26 is reached so long as they are not covered by or eligible for other health insurance through their employer and have completed an “Age 26 Young Adult Dependent Coverage Enrollment Form”.

**PLAN YEAR** - January 1\(^{st}\) through December 31\(^{st}\) (calendar year)

**PLAN MAXIMUM** (Retired Members):

- $6,000 per Retired Member,
- $4,500 for spouse/domestic partner
- $4,500 per dependent child(ren)

**ANNUAL DEDUCTIBLE**: None.

**COVERED EXPENSES**: Charges incurred for the performance of dental services provided for in the SCHEDULE OF COVERED DENTAL ALLOWANCES, when the dental service is performed or under the direction of a duly licensed dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

A dental service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;
- for a crown, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.
PLAN LIMITATIONS

- **Examination** — three in a calendar year.
- **Prophylaxis** — three in a calendar year.
- **X-rays** — $75.00 per calendar year-any combination.
- **Replacement of crowns, bridges and dentures** — not more than once in 5 years.
- **Palliative treatment** — no other treatment rendered that same visit.
- **Fluoride treatment** — to age 19, 2 in a calendar year.
- **Sealant** — to age 19, unrestored permanent posterior teeth, lifetime maximum 1 application per tooth.
- **Root Scaling, curettage, bite correction; any combination, including prophylaxis** — $200 maximum in a calendar year for services provided by a dentist who is not a board certified periodontist. $300 maximum in a calendar year for services provided by a dentist who is a board certified periodontist.
- **Orthodontic treatment** — $3,600 lifetime max, max 24 months active treatment.
- **General Anesthesia** — plan pays for the first 60 minutes only.
- **Specialist Consultation** — one per calendar year, includes allowance for examination.
- **Localized Delivery of Chemo agent.** Three teeth per quad in a three-year period.
PRE-TREATMENT REVIEW

- This process is recommended for your benefit as it will give the dentist and plan Retired Member a better understanding of the dental coverage for a proposed treatment plan before the work begins and expenses are incurred. Please note- a pre-treatment review estimate is not a promise of payment. Work must be done while the patient is still eligible.

- Pre-op periapical x-rays required for crowns, veneers, inlays and extractions.

- Periodontal charting and x-rays are required for surgical periodontal procedures.

- Pre-op periapical x-rays of the entire arch are required for fixed bridgework and removable bridgework.

PERMISSIBLE CHARGES

- Covered and reimbursable services:  None
- Covered but not reimbursable services: Schedule allowance
- Non-covered services:  Your usual charge for that service

COORDINATION OF BENEFITS

If the patient is eligible for benefits under more than one group dental plan, you are entitled to collect benefits available through both plans. The total may not exceed your usual charge and payments from the other plan must first be applied to reduce or eliminate co-payments, deductibles, or charges levied due to maximums.

HOW TO FILE A CLAIM: After dental work is performed, have your dentist complete all items in the Dentist Information portion of the Dental Claim Form and list the procedures, dates of service, and charges, and sign in the space provided for the dentist signature. You should then complete all items in the Retired Member Information portion. Be sure to include spouse and dependent information.  Completed claim forms, with x-rays and other attachments, should be sent to:

Self-Insured Dental Services (SIDS), Dept. 66
Post Office Box 9005
Lynbrook, NY 11563-9005

Claims can be electronically filed: PAYOR ID: CX076
Sample claim forms can be found in the “Sample Forms” section of this booklet. Please photocopy these forms when needed and retain sample for future use. Dental claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed. If you would like the payment made directly to your dentist, you must sign the “Authorization to Assign Benefits” box on the claim form.

Reimbursement will be made according to the Schedule of Covered Dental Allowances, not to exceed the actual dentist charges. Any charges by your dentist above the scheduled allowance shall be your responsibility.

**PRE-TREATMENT REVIEW:** This process is intended to inform you and your dentist, in advance of treatment, what benefits are provided by the Dental Benefits Plan. It enables you to obtain full knowledge of the operation of your Plan prior to undertaking treatment and incurring expenses. A claim form for Pre-Treatment Review should be filed by your Dentist if the course of treatment prescribed for you is expected to cost more than $500 in a 90 day period and/or if it includes any of the following services:

- Crowns;
- Inlays;
- Bridges;
- Dentures;
- Laminate veneers;
- Orthodontics; or,
- Periodontal surgery.

The dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment.

Complete your portion of the claim form and mail it together with the necessary x-rays and other supporting documentation to:

**Self-Insured Dental Services (SIDS), Dept. 66**
**Post Office Box 9005**
**Lynbrook, NY 11563-9005**

SIDS will review the proposed treatment and apply the appropriate Fund provisions. You and your dentist will receive a report showing the exact amount the Fund will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your dentist.

If you receive a pre-treatment authorization for a proposed course of treatment that was submitted by one dentist, that pre-authorization will remain valid if you elect to have some or all of the work done by another dentist. The pre-authorization will be honored for one year after issuance.
Please be aware that a pre-treatment authorization is not a promise of payment.

Work must be done while you are still covered by the Fund for benefits (except where there is an Extension of Benefits), and no significant change occurred in the condition of your mouth after the pre-treatment estimate was issued. Payment will be made in accordance with Plan allowances and limitations in effect at the time services are provided.

ALTERNATE BENEFITS PROVISION:

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on acceptable dental standards. In these instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive alternate course of treatment. This should in no way be considered a reflection on your treating dentist’s recommendations. By using the pre-treatment review and authorization procedures you and your dentist can determine, in advance, what benefits are available for a given course of treatment.

If the course of treatment has already begun, or has been completed without a pre-treatment authorization estimate, the benefits paid by the Fund Dental Plan may be based on the less expensive treatment.

EXTENSION OF DENTAL BENEFITS – An expense incurred in connection with a dental service that is completed after a person’s eligibility for benefits ceases will be deemed to be incurred while that person was eligible if:

♦ For crowns, fixed bridgework and full or partial dentures, a pre-treatment estimate was issued and impressions were taken or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after that person’s eligibility terminated.

♦ For root canal therapy, the pulp chamber of the tooth was opened while that person was still eligible for benefits and the treatment was completed within one month after that person’s eligibility terminated.

NOTE: There is no extension for any dental service not shown above.
EXPENSES NOT COVERED – Covered expenses will not include, and no payment will be made for, expenses incurred for:

1. Treatment solely for the purpose of cosmetic improvement.
2. Expenses due to occupationally related conditions.
3. Replacement of lost or stolen appliances.
4. Replacement of bridges, crowns, or dentures within five (5) years after the date of original installation.
5. Replacement of bridges, crowns, inlays, or dentures that are or can be made usable according to common dental standards.
6. Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
   a) change vertical dimension; or,
   b) diagnose or treat conditions or dysfunctions of the temporomandibular joint; or,
   c) stabilize periodontally involved teeth.
7. Multiple bridge abutments.
8. Charges covered by a no-fault automobile policy.
9. Dental services that do not meet common dental standards.
10. Services not included as Covered Dental Expenses in the Schedule of Covered Dental Allowances.
11. Services for which benefits are not payable according to the “General Limitations” section.
GENERAL LIMITATIONS – No payment will be made for expenses incurred for you or any one of your eligible dependents:

1. For or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party.

2. For or in connection with an injury arising out of, or in the course of, any employment for wage or profit which may be covered under any Worker’s Compensation or similar law.

3. For or in connection with a sickness which may be covered under any Workers’ Compensation or similar law.

4. For charges made by a hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any coverage.

5. For charges that would not have been made if the person had no coverage, including services provided by a Retired Member of the patient’s immediate family.

6. To the extent that payment is unlawful where the person resides when the expenses are incurred.

7. To the extent that they are more than the scheduled benefit allowance.

8. For charges for care, treatment, or surgery which are not deemed to be necessary.

9. To the extent that you or any of your dependents is in any way paid or entitled to payment for these expenses by or through a public program.

10. For or in connection with experimental procedures or treatment methods.

COSMETIC LIMITATION: When there is more than one method of restoring a decayed or fractured tooth, one of which may result in a more esthetic restoration than others, payment will be based on the least costly professionally acceptable treatment option.

GUARDED PROGNOSIS LIMITATION: If, in the opinion of the claims administrator, the longevity of the proposed or rendered treatment is limited, payment may be made in accordance with plan provisions. However, any future benefits for services provided in that jaw may be affected.
WWW.ASONET.COM

This feature of your dental benefits plan is designed to substantially reduce or eliminate the non-reimbursed portion of your dental bill. Since usual and customary dental charges generally exceed Dental Plan reimbursements, you will realize significant savings in the cost of your dental care when you use a participating dental provider.

When you use a participating dental provider you will not incur any out-of-pocket expense, except in the following instances:

- For services listed in the Schedule, but for which the Plan will not pay, for example:
  - a) where dental plan allowances exceed the scheduled per person calendar year maximum.
  - b) where procedure frequency limitations have been met.
- In these instances, the participating dentist’s charges may not exceed the maximum allowances, as stated in the Schedule.
- For non-covered services, you are not required to pay more than the dentist’s usual and customary charge for that service.

The DIRECTORY OF PARTICIPATING DENTISTS can be found on-line at www.asonet.com) information includes the names, addresses, and telephone numbers of General Practitioners, Periodontists, Endodontists, Oral Surgeons, and Orthodontists. While several dentists may practice at the same location, only the dentist whose name appears on the list is an ADWDWA SECURITY BENEFITS FUND Participating Dentist.

Selecting a Dentist - There are no restrictions on the use of a participating dentist. You are free to select the dentist or dental specialist of your choice. Each family Retired Member may select his or her own dentist. You may utilize the services of a participating dental specialist whether or not you use the services of a participating general dentist for your routine care. You may change your dentist at any time, for any reason. It is important to understand that the Fund does not recommend or endorse any particular dentist.
You are responsible to select the dentist of your choice, whether participating or non-participating, and you should exercise the same care and apply the same criteria in selecting a participating dentist that you would in selecting a non-participating dentist.

**Scheduling an Appointment** – After selecting a participating dentist from the directory, call the dental office for an appointment. Identify yourself as a Retired Member of the ADWDWA SECURITY BENEFITS FUND when scheduling your appointment.

Due to the fact that there are occasional additions and deletions to the list of participating dentists, please verify that the dentist is still participating when scheduling your appointment.

If you have any questions, contact Self-Insured Dental Services at 516-396-5500, 718-204-7172, or 800-537-1238 (outside New York State).

**Filing A Claim** - Participating Dentists will handle all the necessary paperwork. You simply complete the Retired Member Information and Assignment of Benefits section of the claim form and payment will be made directly to the Dentist.

**Retired Member Assistance** - If you have any questions regarding the treatment you received or charges incurred when utilizing the services of a Participating Dentist, please call SELF-INSURED DENTAL SERVICES at 516-396-5500.
DIAGNOSTIC & PREVENTIVE

ORAL EXAMINATION .................................................................................................................. 27.00

PANORAMIC FILM .................................................................................................................. 60.00

FULL MOUTH SERIES X-RAYS

10 to 14 periapical and bitewing films ...................................................................................... 75.00

INTRAORAL FILM
Periapical or bitewing, per film (maximum-4 bitewing x-rays per year) ........................................ 6.00

OCCLUSAL FILM .................................................................................................................. 15.00

CEPHALOMETRIC FILM ........................................................................................................ 40.00

A maximum of $75.00 of any of above combination of x-rays per calendar year

CONE BEAM CT .................................................................................................................. 200.00

(one in 36 months)

PROPHYLAXIS, including scaling and polishing

(maximum-three in a calendar year)

adult .......................................................................................................................... 60.00
child, to age 19 ........................................................................................................ 45.00

FLUORIDE TREATMENT- maximum-two in a calendar year

child, to age 19 ........................................................................................................ 15.00

SEALANTS - lifetime maximum-1 application per tooth child, to age 19,
unrestored permanent posterior teeth .................................................................................. 25.00

DIAGNOSTIC CASTS ............................................................................................................ 30.00

SPACE MAINTAINER ........................................................................................................... 150.00

BASIC RESTORATIVE

SILVER AMALGAM FILLINGS

one surface – primary or permanent .................................................................................. 55.00
two surfaces – primary or permanent ................................................................................. 65.00
three surfaces – primary or permanent ............................................................................... 75.00
four or more surfaces-permanent ....................................................................................... 80.00

COMPOSITE RESIN

one surface ......................................................................................................................... 60.00
two surface ....................................................................................................................... 70.00
three or more surfaces ..................................................................................................... 80.00
four or more surfaces involving the incisal angle ............................................................... 90.00

PORCELAIN/METALLIC INLAY

one surface ......................................................................................................................... 250.00
two surfaces ..................................................................................................... 300.00  
three surfaces .................................................................................................. 350.00  
PIN RETENTION-per tooth ........................................................................... 25.00

### MAJOR RESTORATIVE

*Pre-operative periapical x-rays required.*

*There is a five-year frequency limit on replacements.*

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CROWNS</td>
<td></td>
</tr>
<tr>
<td>acrylic jacket</td>
<td>325.00</td>
</tr>
<tr>
<td>porcelain jacket</td>
<td>475.00</td>
</tr>
<tr>
<td>plastic with metal</td>
<td>475.00</td>
</tr>
<tr>
<td>porcelain with metal</td>
<td>550.00</td>
</tr>
<tr>
<td>full or 3/4 cast</td>
<td>475.00</td>
</tr>
<tr>
<td>PORCELAIN LAMINATE</td>
<td>300.00</td>
</tr>
<tr>
<td>STAINLESS STEEL CROWN, primary tooth</td>
<td>85.00</td>
</tr>
<tr>
<td>CROWN BUILD UP</td>
<td>75.00</td>
</tr>
<tr>
<td>POST &amp; CORE-pre-fabricated</td>
<td>80.00</td>
</tr>
<tr>
<td>POST &amp; CORE-cast</td>
<td>130.00</td>
</tr>
<tr>
<td>POST REMOVAL</td>
<td>100.00</td>
</tr>
</tbody>
</table>

### ENDODONTICS

*x-ray evidence of satisfactory completion required*

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>PULP-CAP, direct</td>
<td>10.00</td>
</tr>
<tr>
<td>PULPOTOMY</td>
<td>75.00</td>
</tr>
<tr>
<td>APICOECTOMY, 1st root</td>
<td>275.00</td>
</tr>
<tr>
<td>APICOECTOMY, maximum per tooth</td>
<td>550.00</td>
</tr>
<tr>
<td>RETROGRADE FILLING-per tooth</td>
<td>90.00</td>
</tr>
</tbody>
</table>

**For services provided by a dentist who is not a board certified specialist:**

**ROOT THERAPY**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior</td>
<td>400.00</td>
</tr>
<tr>
<td>Bicuspid</td>
<td>450.00</td>
</tr>
<tr>
<td>Molar</td>
<td>650.00</td>
</tr>
</tbody>
</table>

**For services provided by a board certified Endodontist:**

**ROOT THERAPY**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior</td>
<td>450.00</td>
</tr>
<tr>
<td>Bicuspid</td>
<td>500.00</td>
</tr>
<tr>
<td>Molar</td>
<td>700.00</td>
</tr>
</tbody>
</table>

**RETREATMENT OF ROOT THERAPY**

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior</td>
<td>500.00</td>
</tr>
<tr>
<td>Bicuspid</td>
<td>650.00</td>
</tr>
<tr>
<td>Molar</td>
<td>800.00</td>
</tr>
</tbody>
</table>
**PROSTHODONTIC REPAIRS**

**DENTURE RELINE**
- office procedure-complete .......................................................... 85.00
- office procedure-partial ............................................................. 60.00
- laboratory procedure-complete .................................................. 135.00
- laboratory procedure-partial ..................................................... 110.00

**DENTURE REPAIRS**
- denture adjustment ................................................................. 40.00
- repair cast framework ............................................................. 100.00
- broken denture base ............................................................... 100.00
- replace tooth or broken clasp in denture ................................. 90.00
- replace broken facing ............................................................ 100.00
- add tooth or clasp to existing partial denture ......................... 85.00

**RECEMENT CROWN** .............................................................. 35.00
**RECEMENT SPACE MAINTAINER** .......................................... 40.00
**RECEMENT BRIDGE** ............................................................ 75.00

---

**PROSTHODONTICS**

*Pre-operative periapical x-rays of the entire arch required. There is a five-year frequency limitation on replacements.*

**COMPLETE DENTURE**
- Permanent .................................................................................. 650.00

**PARTIAL DENTURE**
- unilateral ................................................................................... 280.00
- bilateral acrylic base with clasps and rests ................................. 475.00
- cast metal base .......................................................................... 650.00

**PRECISION ATTACHMENT** ....................................................... 135.00

**BRIDGE ABUTMENT**
- crown-plastic with metal ............................................................. 475.00
- crown-porcelain fused to metal ................................................ 550.00
- crown-full cast .......................................................................... 475.00

**MARYLAND BRIDGE RETAINER** ............................................ 280.00

**BRIDGE PONTIC**
- full cast ...................................................................................... 475.00
- plastic with metal ....................................................................... 475.00
- porcelain with metal ................................................................... 550.00
**IMPLANTOLOGY**

There is a lifetime maximum benefit of six implants for a lifetime.

Please be aware that the alternate benefit provision may be applied in certain circumstances. Based on the number of remaining sound natural teeth in a jaw and the treatment prognosis, the alternate benefit of a removable denture may be the benefit determination in lieu of an implant.

Payment for a prosthetic device that is attached to one or more implants will be based on benefit allowances that would be paid if no implant was placed.

---

**IMPLANT SERVICES**

*Pre-operative periapical x-rays of the entire arch required. There is a five-year frequency limitation on replacements*

<table>
<thead>
<tr>
<th>Plan Pays</th>
<th>Item Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Endosteal/Subperiosteal/Transosseous Implant</td>
<td>1,200.00</td>
</tr>
<tr>
<td></td>
<td>Prefabricated Abutment</td>
<td>475.00</td>
</tr>
<tr>
<td></td>
<td>Custom Abutment</td>
<td>475.00</td>
</tr>
<tr>
<td></td>
<td>Interim Abutment</td>
<td>300.00</td>
</tr>
<tr>
<td></td>
<td>Abutment Supported Porcelain Ceramic Crown</td>
<td>700.00</td>
</tr>
<tr>
<td></td>
<td>Abutment Supported Porcelain/Metal Crown</td>
<td>700.00</td>
</tr>
<tr>
<td></td>
<td>Abutment Supported Crown</td>
<td>600.00</td>
</tr>
<tr>
<td></td>
<td>Abutment Supported Cast High Noble Metal Crown</td>
<td>700.00</td>
</tr>
<tr>
<td></td>
<td>Implant Supported Porcelain Ceramic Crown</td>
<td>1,000.00</td>
</tr>
<tr>
<td></td>
<td>Implant Supported Porcelain/High Noble Metal Crown</td>
<td>1,000.00</td>
</tr>
<tr>
<td></td>
<td>Implant Supported High Noble Metal Crown</td>
<td>1,000.00</td>
</tr>
</tbody>
</table>

Implants are limited to 6 per lifetime.
ORAL SURGERY

ROUTINE EXTRACTION ................................................................. 75.00

SURGICAL EXTRACTION (must be demonstrated by x-ray)
  erupted tooth ................................................................. 100.00
  retained root ................................................................. 100.00
  impaction-soft tissue .................................................... 125.00
  impaction-partial bony ................................................... 215.00
  impaction-complete bony ............................................. 250.00

SURGICAL EXPOSURE – IMP/UNERUP (AID ERUPTION) ........... 80.00
SURGICAL EXPOSURE – IMP/UNERUP (FOR ORTHO) ............... 175.00
ALVEOLOPLASTY-maximum per quad .................................... 125.00
FRENULECTOMY ........................................................................ 95.00
BIOPSY OF ORAL TISSUE ....................................................... 85.00
REMOVAL OF CYST OR TUMOR <1.25CM .............................. 85.00
REMOVAL OF CYST OR TUMOR >1.25CM .............................. 125.00
INCISION & DRAINAGE .......................................................... 55.00

no other treatment that visit

ROOT RESECTION/HEMISECTION ........................................... 150.00
GENERAL ANESTHESIA/IV SEDATION per 15 minutes ............. 75.00

Max payable one hour

PERIODONTICS

Although eight teeth constitute the anatomic compliment of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

PEDICLE SOFT TISSUE GRAFT ................................................. 200.00
FREE SOFT TISSUE GRAFT ................................................... 250.00
OSSEOUS GRAFT ................................................................. 125.00
  MAX PER QUADRANT ..................................................... 375.00

Maximum once per thirty-six months

For services provided by a dentist who is not a board certified specialist:

ROOT SCALING, GINGIVAL CURETTAGE and BITE CORRECTION,
  including prophylaxis, per visit ........................................... 50.00
PERIODONTAL MAINTENANCE ............................................... 55.00

Maximum payment-$200 in a calendar year
PERIODONTAL SURGERY
confirmation by charting and/or x-rays required
per quadrant of at least 5 teeth

GINGIVECTOMY, GINGIVOPLASTY and MUCOGINGIVAL SURGERY
per quadrant..................................................................................................... 110.00
OSSEOUS SURGERY
per quadrant..................................................................................................... 375.00

Maximum once per thirty-six months

For services provided by a dentist who is a board certified specialist:

ROOT SCALING, GINGIVAL CURETTAGE and BITE CORRECTION,
including prophylaxis, per visit................................................................. 75.00
PERIODONTAL MAINTENANCE................................................................. 100.00

Maximum payment-$300 in a calendar year

PERIODONTAL SURGERY
confirmation by charting and/or x-rays required
per quadrant of at least 5 teeth

GINGIVECTOMY, GINGIVOPLASTY and MUCOGINGIVAL SURGERY
per quadrant..................................................................................................... 150.00
OSSEOUS SURGERY
per quadrant..................................................................................................... 500.00

Maximum one per thirty-six months

ORTHODONTICS
$3600 lifetime maximum for dependents under age 19

REMOVABLE APPLIANCE-minor tooth movement................................. 270.00
DIAGNOSIS AND INITIAL ORTHO APPLIANCE...................................... 600.00
Active treatment, per month................................................................. 100.00
  Maximum: 24 months........................................................................... 2,400.00
Passive treatment per 3 months........................................................ 100.00
  Maximum: 9 months........................................................................... 300.00
RETENTION APPLIANCE........................................................................... 150.00

ADJUNCTIVE SERVICES

SPECIALIST CONSULTATION (including an oral examination)............... 75.00
PALLIATIVE TREATMENT (no other treatment that visit).......................... 35.00
BRUXISM APPLIANCE............................................................................. 120.00
The Vision Care Plan covers eligible expenses for the following vision care services, which are incurred by you and any of your eligible dependents while covered for these benefits. The benefits may be obtained through a network of participating vision care providers or through direct reimbursement. A vision care service consists of the following:

1. Eye examinations performed by a licensed optometrist or licensed physician accredited in the specialty of the eye, one per calendar year; and,

2. Lenses and frames ordered by such practitioner (two pair for active Retired Member, one pair for spouse/domestic partner/dependents, per calendar year).

**BENEFITS:**

You will be reimbursed for the amount charged for examinations and materials, up to the maximum amounts shown in the following Schedule.

**VISION CARE SCHEDULE OF BENEFITS**

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td></td>
</tr>
<tr>
<td>Without ophthalmologic tests</td>
<td>10.00</td>
</tr>
<tr>
<td>With ophthalmologic tests</td>
<td>20.00</td>
</tr>
<tr>
<td>Lenses:</td>
<td></td>
</tr>
<tr>
<td>Each single vision lens (including cosmetic contact lens)</td>
<td>15.00</td>
</tr>
<tr>
<td>Each bi-focal lens</td>
<td>20.00</td>
</tr>
<tr>
<td>Each tri-focal lens</td>
<td>25.00</td>
</tr>
<tr>
<td>Each lenticular lens</td>
<td>45.00</td>
</tr>
<tr>
<td>Frames</td>
<td>40.00</td>
</tr>
</tbody>
</table>
EXCLUSIONS – The following services are not covered:

1. Services and materials:
   (a) In connection with special procedures such as orthoptics and visual training, or,
   (b) In connection with medical or surgical treatment, or,
   (c) Provided under any Workers’ Compensation or similar law.

2. Eye examinations required by:
   (a) An employer as a condition of employment, which the employer is required to provide by virtue of a labor agreement; or,
   (b) A governing body.

3. Replacement of lenses or frames which were furnished under this Plan and which have been lost, stolen, or broken.

HOW TO FILE A CLAIM FOR DIRECT REIMBURSEMENT: After vision care services are received, have your optical care provider complete all items in the Provider Information sections (one section is for examination, and one is for dispensing of frames and lenses) of the Vision Claim Form and list the procedures, dates of service, and charges, and sign in the space provided for his/her signature. You should then complete all items in the Retired Member Information section. Be sure to include spouse and dependent information.

Completed claim forms, with any attachments, should be sent to:

Administrative Services Only, Inc., Dept. 66-O
Post Office Box 9005
Lynbrook, NY 11563-9005

Sample claim forms can be found in the “Sample Forms” section of this booklet or via website www.asonet.com.

Please photocopy these forms when needed and retain sample for future use. Vision care claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed.

If you would like the payment made directly to your optical service provider, you should sign the “Assignment of Benefits” box on the claim form. Reimbursement will be made in accordance with the Vision Care Schedule of Benefits, not to exceed the actual charges.
VISION CARE PARTICIPATING PROVIDER OPTION

Provides Retired Member and their eligible dependents with the option of receiving covered optical services from Participating Providers, eliminating or substantially reducing any out-of-pocket expenses.

When a Retired Member or his/her eligible dependent uses the services of a Participating Vision Care Provider, the following services will be provided at no cost (subject to the Exclusions and Limitations noted previously in this section):

✓ A comprehensive eye examination, including glaucoma testing;
✓ A selection of up-to-date frame styles in many colors and sizes;
✓ First quality plastic or glass lenses including oversized lenses; and,
✓ Cosmetic or sun tinting of lenses.

30% discounts are provided for any additional eyewear purchases that are not otherwise covered by the Plan.

Currently, the Fund’s Participating Vision Care Provider Organizations are:

A. Vision Screening Optical Centers, with over 145 optical center locations.

NEW YORK STATE ONLY

How do I receive my covered Vision Screening optical services?

• Call the Vision Screening optical network provider of your choice listed on their website www.visionscreeninginc.com and schedule an appointment.

• Identify yourself as a Retired Member or dependent of the ADWDWA Security Benefit Fund.

• Sign the claim form at the time of your visit. (Sample claim forms can be found in the “Sample Forms” section of this booklet or via website www.asonet.com.

Please photocopy these forms when needed and retain sample for future use. Vision care claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed.
If you would like the payment made directly to your optical service provider, you should sign the “Assignment of Benefits” box on the claim form. Reimbursement will be made in accordance with the Vision Care Schedule of Benefits, not to exceed the actual charges."

At any Vision Screening Optical Location, receive the following at NO COST to You:

- **LENSES**: First quality lenses in glass or plastic which includes single vision and bifocal.
- **CONTACT LENSES**
- **ADDITIONAL DISCOUNTS**: For members and their families who are not eligible or who have used their optical benefits, a 30% discount on non-covered items will be offered.

**B. Comprehensive Professional Systems, with over 300 optical center locations.** (to find a participating eye care professional in your area please visit CPS Optical at:www.cpsoptical.com).

**NEW YORK STATE ONLY**

How do I receive my covered CPS optical services?

- Call the CPS optical network provider of your choice listed on the following pages and schedule an appointment.
- Identify yourself as a Retired Member or dependent of the ADWDWA Security Benefit Fund.
- Sign the claim form at the time of your visit. (Sample claim forms can be found in the “Sample Forms” section of this booklet or via website www.asonet.com.

Please photocopy these forms when needed and retain sample for future use. Vision care claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed.

If you would like the payment made directly to your optical service provider, you should sign the “Assignment of Benefits” box on the claim form. Reimbursement will be made in accordance with the Vision Care Schedule of Benefits, not to exceed the actual charges.)
At any CPS Private Practice Optical Location, receive the following at NO COST to You:

- A wide selection of frames fully covered.
- A comprehensive eye exam including tonometry (not covered outside NY); and single vision plastic lenses and a frame, or Flat top 25/28/35 or Executive or Blended plastic bifocal lenses and a frame; or,
- Trifocal plastic lenses and a frame, or Progressive lenses (including Varilux Comfort, Varilux Panaric, Varilux Ellipse, Kodak Concise and Kodak Precise) and a frame, or Transitions lenses and a frame (co-pay of $25), or Prescription Sunglasses.
- Cosmetic tint, Ultra violet coating, Scratch resistant coating, Photosensitive Glass and Oversize included, at no additional cost. Polycarbonate lenses will be provided for children under the age of 19, and for all monocular patients.
- Conventional soft daily wear contact lenses (soft spherical clear), including fitting and follow-up or One-year disposable contact lenses (soft spherical clear), including fitting and follow up.

C. **DavisVision, with over 48,000 points of access, in both private practice and retail settings**. (to find a participating eye care professional in your area please visit DavisVision at: www.davisvision.com).

**DAVISVISION CAN ONLY BE USED FOR RETIREES WHO LIVE OUT-OF-NEW YORK STATE.**

Just register and log in to the DavisVision Retired Member Portal and use the “Find a Provider” tool. You will be able to search for providers based on ZIP codes not in **NEW YORK STATE**. You may call 1-800-999-5431.

- You may Contact DavisVision Retired Member Services to recommend a provider be added to their network; a Customer Service Representative will complete a provider nomination request form on your behalf. DavisVision will make every effort to include your provider in their network, however all nominations are subject to credentialing and geographic review.
- If you are visiting a DavisVision network provider, there is no need for a claim form. Just make your appointment, and your provider will verify your eligibility and benefits and handle the rest. Your vision benefit includes an “out-of-network benefit” and if you visit an out-of-network provider, you will be responsible to pay the provider’s charges at the time of service.
• The DavisVision Service Department offers foreign translation in over 170 different languages through AT&T’s Language Line. Simply contact a Retired Member Service Representative at 1-800-999-5431 and ask for translation assistance. The DavisVision Portal is also available in Spanish.

• All DavisVision eyeglasses are covered by a one-year breakage warranty: If your glasses were manufactured by DavisVision labs, they are covered by their one-year unlimited breakage warranty. This means that it doesn’t matter how your glasses broke, DavisVision will repair or replace them at no charge. (Eyeglasses manufactured by non-DavisVision labs are covered by a one-year breakage warranty under the terms of normal wear.)

RETIRED MEMBERS ONLY - are entitled for a second pair of eyeglasses covered by the ADWDWA Security Benefits Fund. (Applicable co-pays may apply.)

Contact Administrative Services Only, Inc. for each of the Vision Care Participating Provider Organization’s listings of vision center locations.

Filing A Claim in New York State - Participating Optical Centers will handle all the necessary paperwork. You simply complete the Retired Member Information and Assignment of Benefits section of the Vision Care Claim Form and payment will be made directly to the Provider.

Filing a claim for direct reimbursement (NON PARTICIPATING PROVIDER- ONLY), where applicable - After vision care services are received, have your optical care provider complete all items in the Provider Information sections (one section is for examination, and one is for dispensing of frames and lenses) of the Vision Claim Form and list the procedures, dates of service, and charges, and sign in the space provided for his/her signature.

You should then complete all items in the Retired Member Information section. Be sure to include spouse and dependent information.

For RETIRED Members residing in New York State - Completed claim forms, with any attachments, should be sent to:

Administrative Services Only, Inc., Dept. 66-O
Post Office Box 9005
Lynbrook, NY 11563-9005

For Retired Members residing outside of New York State - Completed claim forms, with any attachments, should be sent to:

DAVIS VISION
Post Office Box 1525
Latham, NY 12110
BENEFITS: The New Dependent allowance is a benefit payable in all cases where a child is born to a Retired Member. The Fund will reimburse $2000 for each child born to the Retired Member. This benefit is not available to be assigned to any hospital or medical care provider.

HOW TO FILE A CLAIM: After the birth, the Retired Member must complete all items (Patient Information, Retired Member Information, Spouse Information, Provider Information and Authorization to Release Information) of the New Dependent Benefits Claim Form.

Completed claim forms, must be accompanied by:

(1) a copy of a hospital bill or physician’s bill including the patient’s name and dates of service;

(2) a copy of the Explanation of Benefits Statement from your basic medical insurance carrier; and,

(3) a copy of the birth certificate for your newborn child.

The claim form and appropriate supporting documentation should be sent to:

Administrative Services Only, Inc., Dept. 66-E
Post Office Box 9005
Lynbrook, NY 11563-9005

Sample claim forms can be found in the "Sample Forms" section of this booklet or via website www.asonet.com.

Please photocopy these forms when needed and retain sample for future use. The New Dependent Benefits claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed.
**HEARING AID BENEFIT**

**BENEFITS:** The Hearing Aid Benefits Plan will cover Retired Members and their eligible dependents for one (1) hearing aid per ear, in a four year period, with a maximum of $1500 reimbursement, per ear for the purchase of new hearing aid devices.

**EXCLUSIONS:** No benefits will be payable for:

1) Expenses not recommended or approved by a physician or audiologist.
2) Medical or surgical treatment of the ear or ears.
3) Non-durable equipment such as batteries.
4) Rental, trial period or repairs of hearing aids.

**HOW TO FILE A CLAIM:** You must complete all items, (Patient Information, Retired Member Information, Spouse Information, Audiologist Information, Dealer Information and Authorization to Release Information Sections) of the Hearing Aid Benefit Claim Form.

*Completed claim forms, which must be accompanied by: (1) a copy of a bill including the patient’s name and type of device purchased and, (2) a copy of the Explanation of Benefits from your basic medical insurance carrier, should be sent to:*

Administrative Services Only, Inc., Dept. 66-H
Post Office Box 9005
Lynbrook, NY 11563-9005

Telephone: (516) 396-5500
(718) 204-7172
Toll Free: (800) 537-1238

Sample claim forms can be found in the “Sample Forms” section of this booklet via website www.asonet.com. Hearing Aid claims must be filed within 12 months after the date of service. Claims filed later than 12 months from the date of service will not be reimbursed.
HEALTH & WELLNESS BENEFIT

BENEFITS: The Health & Wellness Benefit is available for all Retired Members who incurred $300 in health and wellness expenses (listed below), during the benefit period of November 1st thru October 31st. This benefit is not available to be assigned to anyone other than the Retired Member.

HOW TO FILE A CLAIM: After you have accumulated $300 in expenses, you must complete all the items of the Health & Wellness Benefit Claim Form.

Eligible benefits include:

- **OPTICAL/DENTAL EXPENSES - Retired Member Only** (over and above that which is already covered by the Fund) - up to $300 per plan year;

- **WEIGHT LOSS PROGRAMS - Retired Member Only** (this benefit does not include reimbursement for prescription medications or devices utilized for weight loss) (you must also submit evidence of attendance of the program) - up to $300 per plan year;

- **FITNESS PROGRAMS - Retired Member Only** (can be individual classes or gym membership; evidence of attendance is required), up to $300 per plan year; and/or,

- **LIFE INSURANCE PREMIUMS - Retired Member Only** - up to $300 per plan year; and/or,

- **CANCER, SICKNESS OR ACCIDENT INSURANCE PREMIUMS (Non-Auto)** - Retired Member Only - up to $300 per plan year.

*Completed claim forms, which must be accompanied by:*

*Proof of* OPTICAL/DENTAL EXPENSES, WEIGHT LOSS PROGRAMS, FITNESS PROGRAMS, LIFE INSURANCE PREMIUMS and/or CANCER, SICKNESS OR ACCIDENT INSURANCE PREMIUMS;

*Mail to:*

Administrative Services Only, Inc., Dept. 66-P
Post Office Box 9005
Lynbrook, NY 11563-9005

Sample claim forms can be found in the “Sample Forms” section of this booklet or via website www.asonet.com. Please photocopy these forms when needed and retain sample for future use. Health & Wellness Benefits claims must be filed within 12 months after the end of the calendar year in which the eligible expenses were incurred. Claims filed later than 12 months will not be reimbursed.
SURVIVOR CONTINUATION BENEFIT PLAN

Who is covered?

The ADWDWA Security Benefits Fund protects your survivors if you should die. If you die while a Retired Member, your eligible survivors, who are your lawful spouse or domestic partner who has not remarried and your dependent children, as defined in the Eligibility section, are covered for this benefit at the time of the Retired Member's death.

What are the benefits?

- **Waiver of the Security Benefits Fund COBRA payment**: COBRA coverage for the Security Benefits Fund's benefits, Dental, Vision, and Supplemental Health Benefits will be extended to the eligible survivors at no cost for the first twelve months. The surviving spouse will also retain twelve months eligibility from the Retired Member's date of death.

How are benefits obtained?

A Retired Member of the family or named beneficiary of the deceased Retired Member should notify the Fund Administrator of the Fund's Third Party Administrator, Administrative Services Only, Inc., of the death of the Retired Member and request the survivor benefits form. The form must be returned to the Fund office and include a certified copy of the Retired Member’s death certificate.

In order to obtain a waiver of Security Benefits Fund COBRA payments, the eligible survivor must elect COBRA as set forth on the City’s election form.

**Note**: The election of City COBRA does not automatically enroll you in COBRA for the Security Benefits Fund. You must indicate on the City COBRA form that you wish to enroll in COBRA from your Security Benefits Fund (sometimes referred to by the City as the "Welfare Fund").
WHAT IS THE RETIRED MEMBER ADVOCACY SERVICE?

The Security Benefit Fund has arranged for a **Retired Member Advocacy Service** to assist you with any problems you may experience with your basic health plan provided by the City. This service, available at no cost to all Retired Members of the Assistant Deputy Wardens/Deputy Wardens Association Security Benefit Fund, is a unique program designed to help guide Retired Members through the increasingly complex and time consuming health care system. By utilizing this service, you have access to an experienced medical advocacy representative who will work with you towards the goal of resolving any problems that you may be experiencing with your health insurance carrier. This service can assist you with the confusion and frustration you may experience in trying to resolve issues with your health insurance company.

The Retired Member Advocacy Services staff has the health care system and claims processing experience, knowledge of medical terminology, and communication skills needed to navigate the complex and constantly changing health care environment.

A medical advocacy representative will work with you towards resolving such problems as:

- ✓ Plan provisions
- ✓ Levels of reimbursement
- ✓ Participating provider/in-network situations
- ✓ Claim payment denials
- ✓ Status of claims filed
- ✓ Appeals filing

**How to use the Retired Member Advocacy Service:**

When you have a problem with your basic health plan and feel that this problem has not been resolved to your satisfaction, simply complete a “Retired Member Advocacy Form”.

Complete the Patient, Retired Member, and Spouse Information sections of the form, sign the Authorization section, provide a brief description of your problem, and attach copies of all relative documentation and correspondence that you have sent to or received from your health insurance carrier.
Mail the completed form and attachments to:

Administrative Services Only, Inc., Dept. 66-A
Post Office Box 9005
Lynbrook, NY 11563-9005

PLEASE NOTE: Administrative Services Only, Inc. does not guarantee that the Medical Advocacy Service will resolve your problem to your satisfaction. Your basic health plan insurance contract and the administrative practices and internal controls of the insurance company will determine the outcome of your inquiry. This program does not provide legal
**INNER IMAGING/ BODY SCAN BENEFIT**

**BENEFITS:** Covers full body scanning to detect diseases of the heart, lungs, etc., in the early stages. All Active Members and their spouses/enrolled domestic partners receive a $300.00 benefit payment towards any of the tests specified below.

The Inner Imaging/Body Scan Benefit is limited to one exam every five years, unless it is determined that the Active Member or their spouse/enrolled domestic partner requires more extensive testing and analysis.

**WHAT IS INNER IMAGING:** Inner Imaging offers advanced imaging called Electron Beam Tomography (EBT). Recognized as the Gold Standard in Heart Scanning, EBT is clinically proven to detect coronary artery disease (plaque) long before symptoms occur when it is preventable.

**WHAT IS THE BEST ALTERNATIVE? EBT:** Heart Scanning with Electron Beam Tomography (EBT) can see coronary artery disease (plaque) as much as fifteen years before symptoms occur with an accuracy (sensitivity) of between 98-99%. It can catch it early.

**WHY THIS TEST?:** Coronary Artery Disease (CAD) Facts

- 1,600,000 people will suffer a heart attack this year.
- For 500,000 people the first symptom of heart disease is death.
- One person per minute will die from a heart attack.
- Majority of heart attacks occur in people with normal cholesterol levels.
- 68% of heart attacks occur in arteries that are less than 50% blocked.
- 56% of those who pass their stress test have advanced coronary artery disease that will go undetected.
- Uniformed Correction Personnel are more likely to develop Heart and Lung disease due to occupational conditions.
WHO SHOULD HAVE THE TEST?: Generally, men over 35, and women over 45. Those with one or more risk factors should consider the Heart Scan.

NOTE: Stress testing detects advanced disease, when the artery is already blocked. The EBT Heart Scan can detect disease early when it is treatable, greatly reducing your risk of a heart attack.

HEART SCAN RESULTS: The results of this quick and easy Heart Scan provide you and your doctor with information that could save your life.

- True cardiac risk assessment
- Early detection of coronary plaque
- Determination of drug treatments
- Evaluate effectiveness of therapy

RISK FACTORS FOR CAD

- Family History of CAD
- Diabetes
- High Cholesterol
- High Blood Pressure
- Smoking History
- Lack of Exercise
- Obesity
- Stress

RADIATION: The dosage for the EBT Heart Scan is 0.5 millisieverts. This equals 2 months of radiation from the sun or 5 chest X-Rays or 8 round trip flights to California. EBT is 8 to 22 times less radiant than a conventional CAT scan (64 Slice).

AMERICAN HEART ASSOCIATION 2007: Inner Imaging is the only center in New York to provide you with EBT Technology. Recognized by the American Heart Association, the EBT Heart Scan is the most sensitive non-invasive test proven to assess your true risk of future heart attack.

THE SAINT FRANCIS HEART STUDY: Published in the Journal of the American College of Cardiology July 2005, establishes the prognostic accuracy of EBT to greatly out-weigh that of the Framingham risk factor analysis. This landmark study is the largest randomized, population-based clinical study to date and involves more than 4,000 people representative of the American population.
LIMITATIONS: This $300.00 benefit is limited to one (1) exam every five (5) years, unless it is determined that the Member requires more extensive analysis or review. The tests must be done at an Inner Imaging facility. This benefit is limited to the Member and their spouse/enrolled domestic partner, only.

The advanced screening tests include:

- Heart Scan
- Lung Scan
- Full Body Scan
- Virtual Colonography
- Non-invasive EB Angiography
- Nuclear Stress Testing

The cost of the exams are as follows:

<table>
<thead>
<tr>
<th>EXAM</th>
<th>MEMBER FEE</th>
<th>ADWDWA BENEFIT</th>
<th>TOTAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart &amp; Lung Screening</td>
<td>$50.00</td>
<td>$300.00</td>
<td>$350.00</td>
</tr>
<tr>
<td>Heart – Lung – Abdomen – Pelvis (Full Body)</td>
<td>$75.00</td>
<td>$300.00</td>
<td>$375.00</td>
</tr>
<tr>
<td>Virtual Colonography (VC)</td>
<td>$125.00</td>
<td>$300.00</td>
<td>$425.00</td>
</tr>
<tr>
<td>Nuclear Stress Testing</td>
<td>$15.00</td>
<td>$0.00</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

(A medical insurance covered test)

LOCATION OF EXAM OFFICE:

Inner Imaging
307 East 63rd Street
New York, NY 10065

212-991-5445 Phone
212-991-5450 Fax

HOW TO FILE A CLAIM: After the Active Member has a Body Scan done at Inner Imaging, the Member must complete all items (Member Information, Spouse/Domestic Partner Information, Authorization to Release Information and Assignment of Benefits) of the Inner Imaging Benefit Claim Form. Completed claim forms, must be accompanied by a copy of the paid bill from Inner Imaging with the patient’s name and the date of service.
HEART SCAN SCREENING BENEFIT

BENEFITS: Heartscan Services identifies early risk factors of Heart Disease, Stroke, PAD (peripheral arterial disease and diabetes), Hypertension and Thyroid nodules. The screening is non-invasive, takes approximately 30 minutes, and no preparation is required. Heartscan Services is mobile and can perform screening at various locations, making it convenient for all members to take advantage of this program.

THERE IS A $75 COPAY

To set up an appointment contact Heart Scan Services at 1-866-518-1112

LIMITATIONS: This benefit is limited to one benefit exam per calendar year. The tests must be done at an HEARTSCAN SERVICES facility. This benefit is limited to the Member and their spouse/registered domestic partner, only.

The advanced screening tests include:

- **ECHOCARDIOGRAM** - looks at size, shape and movement of the heart. Heart Disease can be prevented if found early.

- **CAROTID ARTERY ULTRASOUND** – can identify plaque in the carotid arteries, which can lead to stroke.

- **ABI INDEX** – looks for peripheral arterial diseases and early diabetes.

- **THYROID SCREEN** – looks for nodules. Thyroid Cancer is the fastest increasing cancer in the United States.

Member/spouse/registered domestic partner must present proper documentation including Department of Correction identification card (spouse may present copy) and driver’s license.
FUNERAL BENEFIT

**BENEFITS:** The Funeral Benefit has been established to help offset the funeral expenses of dependent children. The $5,000.00 benefit will be payable upon the death of an eligible dependent child, or if the child is physically or mentally incapable of self-support and the proper documentation has been filed with the Security Benefits Fund.

This benefit is not payable for the death of the Retired Member, the Retired Member's spouse, or a child who is not considered a dependent according to the eligibility guidelines mentioned above.

**HOW TO FILE A CLAIM:** To request this benefit, please contact the Fund Administrator:

Administrative Services Only, Inc.  
Post Office Box 9005  
Lynbrook, NY 11563-9005

(516) 396-5500 / (800) 537-1238
TERM LIFE INSURANCE

Term life insurance will be paid to any beneficiary you name if you die from any cause. You may change your beneficiary whenever you wish, by contacting Administrative Services Only (at the telephone numbers previously listed) and requesting a new enrollment card to complete and return. You are urged to keep your beneficiary data up to date.

For a detailed booklet containing specific policy provisions please contact the plan administrators.

The plan is administered by:

Amalgamated Life Insurance Co.  Contact:  Debbie Internicola
333 Westchester Avenue
White Plains, NY 10604   (646) 522-0370

AMOUNT OF TERM LIFE INSURANCE

Retired Members who retired:

- On or after January 1, 2007 ............................................................ $75,000
  (Reduced at age 70) ............................................................... $5,000
- On or after February 1, 1997 .......................................................... $50,000
  (Reduced at age 70) ............................................................... $5,000
- On or after January 1, 1979 ............................................................. $20,000
  (Reduced at age 70) ............................................................... $5,000
- Prior to January 1, 1979 ..................................................................... $4,000

CHANGE TO AN INDIVIDUAL POLICY

You may elect to buy an individual life insurance policy if your life insurance is reduced or ends because of:

- Termination of Retired Membership in the class or classes eligible for coverage under the policy;
- Termination of the policy;
- Attainment of a particular age;
- Change in class; or
- Amendment of the policy.

No evidence of good health will be required for the converted policy.
You must apply to the life insurance carrier and pay the first premium for the converted policy. If you are notified of the right to convert within 15 days before or after the change in life insurance, this must be done within 31 days of the change. Then the converted policy will take effect 31 days after the change. If you are not notified in that period, the time to apply is extended to the earlier of 45 days after notice is given or 90 days after the change. The converted policy will take effect on the later of 31 days after the change or when the premium is first paid.

For a detailed booklet containing specific policy provisions please contact the plan administrators.

The plan is administered by:

**Amalgamated Life Insurance Co.**
333 Westchester Avenue
White Plains, NY 10604
(914) 364-5550

Contact: Debbie Internicola
(646) 522-0370