ASSISTANT DEPUTY WARDENS
DEPUTY WARDENS ASSOCIATION
Security Benefits Fund

ACTIVE MEMBER

C/o Administrative Services Only, Inc.
303 East Merrick Rd
Lynbrook, NY 11563
516-396-5500/718-204-7172

Dear Member: Jun 2017

The Trustees are pleased to provide you with this Comprehensive Benefits Booklet describing the benefits that are available to you as an Active Member of the Assistant Deputy Wardens/Deputy Wardens Security Benefits Fund and the Annuity 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. 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 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

TABLE OF CONTENTS

GENERAL INFORMATION

Each section of this booklet contains detailed claim filing instructions. Original claim forms are enclosed. Please retain these forms and print/photocopy when necessary. For claim/benefit inquires 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 assistance in filing an appeal on a benefit determination by your Basic Health Insurance Plan call the **Member Advocacy Program** call:

(516) 396-5536

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 an Active Member of the ADW/DWA Security Benefits Fund to avoid any delay and to make sure that the appropriate information is provided to you.

ELIGIBILITY

ELIGIBLE MEMBERS

All Assistant Deputy Wardens and Deputy Wardens 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, provided that they are ***actively employed.***

(Retirees should refer to the separate booklet for Retired Members.)

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 Fund 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 include your natural children and legally adopted children, including children in a waiting period prior to finalization of adoption from age 14 days through 19 years. With the exception of Dependent Term Life Insurance and Orthodontic Benefits, unmarried dependent children over age 19 but less than age 23 are also eligible for Security Fund benefits, provided that they are chiefly dependent upon you, the Member, for support and maintenance and are full-time students in an educational institution. Proof of attendance at an educational institution should be attached to any claim submitted for a child between the ages of 19 and 23.

Currently, ***children up to age 26*** are eligible for coverage for dental and optical benefits only. This policy is subject to review and change by the Board of Trustees on an annual basis.

Stepchildren and children of your registered Domestic Partner may be eligible for benefits provided that they are chiefly dependent upon you, the 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 19, or age 23 if attending an educational institution on a full-time basis, 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 19 or 23). Additional proof will be required periodically.

Other children for whom you have been granted, by a court, legal guardianship or custody, as evidenced by a court order, up to the applicable age of majority.

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/Custody papers, if applicable; and,

6. For physically or mentally disabled, dependent children under the age of eligibility as defined earlier: 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 an Actively Employed Member

If an eligible actively employed Member dies while still covered under the Fund, an extension of twelve months eligibility from the Member's date of death will be provided for the Member's eligible dependents for the following benefits: Dental, Vision, Hospital Income, and New Dependent .

For Terminated Members and their Eligible Dependents

If an eligible actively employed Member is terminated for acts that occurred while performing his/her duties as an ADW, DW or DWIC; and he/she has at least 19 years of service with the Department of Correction; and he/she has completed probation as an ADW, the Fund will provide an extension of Fund benefits for 12 months and pay COBRA premiums for City/employer health coverage for 12 months for the Member and his/her eligible enrolled dependents.

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.

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 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 Member or any other person.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered Member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled, to the extent it pays out benefits, to reimbursement from the covered Member or dependent from any recovery obtained 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 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 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 affect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

BENEFITS PAYABLE ON BEHALF OF DECEASED MEMBER

With respect to any benefits payable to a deceased Member upon the date of death, or with respect to death benefits payable by virtue of the death of the Member where the member's designated beneficiary has predeceased the Member and a successor has not been designated, or where the 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 Member's:

A. Surviving spouse and/or enrolled domestic partner;

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

C. If no surviving children, to the covered 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 Member or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees:

ADW/DWA 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 or an enrolled dependent 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 and those of your eligible enrolled dependents until the overpayment is recouped.

COORDINATION OF BENEFITS

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 Member of the Security Benefits Fund, then the Security Benefits Fund will pay benefits first, while a plan covering a 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 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 members should file claims under each plan. 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.

COBRA CONTINUATION OF COVERAGE

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 "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/member (or retired employee/member) covered under the Fund's plan, the covered employee's/member's spouse/domestic partner, and the dependent children of the covered employee/member.

Continuation coverage is the same coverage that the Fund's plan gives to other 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 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 Member's/ employee's death, divorce or legal separation, the 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 member's/employee's hours of employment with the New York City Department of Correction, and the member/employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the 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 Members.

Continuation coverage may also be terminated for any reason that the Fund would terminate the coverage of a 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 Administrator 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 member/employee, divorce or separation from the covered member/employee, the covered 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 member's/employee's spouse may elect continuation coverage even if the 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 member/employee or the 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 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 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 members. You should also keep a copy, for your records, of any notices you send to the Fund's Administrator.

NOTICE OF PRIVACY PRACTICE

The Health Insurance Portability and Accountability Act, ("HIPAA"), a federal law, requires the ADW/DWA 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 Members of the Fund and is distributed to all new 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.

DENTAL BENEFITS PROGRAM

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 Member must choose a plan upon initial enrollment in the Plan. The Dental Option that the 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.

SERVICE	Dentcare /HealthPLEX Capitation Plan*	ASO/SIDS PPO Participating Providers	ASO/SIDS NON-PPO Non-Participating Providers
Exam/Cleaning	1 Every 6 Months	3 /Calendar Year	3/Calendar Year
Fluoride	1 Every 6 Months	2/Calendar Year	2/Calendar Year
Full Mouth X-Ray Bitewing X-Ray	1 Series/36 Months	$75 per year MAX	$75 per year MAX
Crowns/ Limitations	Once/5 Years	No Copayment Once/5 Years	As per Schedule Once/5 Years
Fixed Bridges/ Limitations	Once/5 Years	No Copayment Once/5Year	As per Schedule Once/5 Years

SERVICE	Dentcare /HealthPLEX Capitation Plan*	ASO/SIDS PPO Participating Providers	ASO/SIDS NON-PPO Non-Participating Providers
Partial Dentures/ Limitations	No Copayment Once/5 Years	No Copayment Once/5 Years	As per Schedule Once/5 Years
Full Dentures/ Limitations	No Copayment Once/5 Years	No Copayment Once/5 Years	As per Schedule Once/5 Years
Orthodontia Active Treatment	Maximum 24 Months Dependent Children Only	Maximum 24 Months $3,600 lifetime MAX for dependents under age 19	Maximum 24 Months $3600 lifetime MAX for dependents under age 19
Lost or Broken Orthodontic Appliance	Not Covered	Non Covered Service	Non Covered Service
Prosthetic Repair	No Charge	No Co-Pay	Per Schedule
General Anesthesia/IV Sedation	Non Covered Service	No Co-Pay	Per Schedule
Broken Appointment	$30 Charge if Not Cancelled with 24-Hour Notice	According to Individual Office Policy	According to Individual Office Policy
Office Hours	Subject to Dentist Schedule	Subject to Dentist Schedule	Subject to Dentist Schedule
Office Selection	You Must Choose One Dental Office	Select from a Participating List	Freedom of Choice
Out of Area Emergency	Up to $25 per Individual per Year	Plan Pays According to Schedule	Plan Pays According to Schedule
Specialists	Usually Referred to Another Office	Refer to PPO Listing	Plan Pays According to Schedule
Implants	Not Covered	No Co-Pay	Per Schedule

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 Department of Financial Services (formerly known as the 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. They 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 covered 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 covered family member per contract year, upon presentation of bills for palliative care rendered by a non-participating dentist until treatment can be obtained from your participating provider.

In the event you are unable to reach your own affiliated dentist, DENTCARE / 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

Oral Examination	No Charge
Full mouth x-ray	No Charge
Single Films (periapical or bitewing)	No Charge
Bitewing Series	No Charge
Cleaning of Teeth (prophylaxis & polishing)	No Charge
Fluoride Treatment	No Charge
Specialty Consultation	No Charge
Treatment in case of dental emergency	No Charge
Broken Appointment without 24-hour notice	$30

RESTORATIVE DENTISTRY

Silver amalgam, one surface	No Charge
Silver amalgam, two surfaces	No Charge
Silver amalgam, three surfaces or more	No Charge
Composite filling, one surface.	No Charge
Composite filling, two surfaces	No Charge
Composite filling, three surfaces or more	No Charge

ORAL SURGERY

Routine extractions — per tooth	No Charge
Surgical extractions	No Charge
Soft tissue impactions	No Charge
Bony impaction	No Charge
Alveolectomy, per quadrant	No Charge

ROOT CANAL THERAPY

Pulp Capping, Direct	No Charge
Pulpotomy	No Charge
Root Therapy — Anterior	No Charge
Root Therapy — Bicuspid	No Charge
Root Therapy — Molar	No Charge
Apicoectomy	No Charge

PERIODONTICS

Scaling of teeth, per quad	No Charge
Gingivectomy, per quad	No Charge
Osseous surgery, per quad	No Charge

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 HealthPLEX 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 alternate procedure.

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.

PLAN YEAR - January 1st through December 31st (calendar year)

PLAN MAXIMUM (Active Members):

$6,000 per Member,
$4,500 for spouse/domestic partner
$4,500 per eligible 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 by 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 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 BY PARTICIPATING PROVIDERS

- Covered and reimbursable services: None

- Covered but not reimbursable services: Schedule allowance

- Non-covered services: Dentist's usual charge for that service

COORDINATION OF BENEFITS

If the patient is eligible for benefits under more than one group dental plan, the participating dentist is are entitled to collect benefits available through both plans. The total may not exceed the dentist's 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 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 will 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 must 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 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.

ASSISTANT DEPUTY WARDENS/DEPUTY WARDENS ASSOCIATION SECURITY BENEFITS FUND ASO/SIDS PARTICIPATING DENTAL PROGRAM

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 schedule 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 ADW/DWA 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 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 Member of the ADW/DWA 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 Member Information and Assignment of Benefits section of the claim form and payment will be made directly to the Dentist.

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.

ADWDWA SECURITY BENEFITS FUND
ASO/SIDS SCHEDULE OF COVERED DENTAL ALLOWANCES

DIAGNOSTIC & PREVENTIVE

ORAL EXAMINATION 27.00
maximum-three in a calendar year
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
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.

CROWNS	
acrylic jacket	325.00
porcelain jacket	475.00
plastic with metal	475.00
porcelain with metal	550.00
full or 3/4 cast	475.00
PORCELAIN LAMINATE	300.00
STAINLESS STEEL CROWN, primary tooth	85.00
POST & CORE-pre-fabricated	80.00
POST & CORE-cast	130.00
POST REMOVAL	100.00
CROWN BUILD-UP	75.00

ENDODONTICS

x-ray evidence of satisfactory completion required

PULP-CAP, direct	10.00
PULPOTOMY	75.00
APICOECTOMY, 1st root	275.00
APICOECTOMY, maximum per tooth	550.00
RETROGRADE FILLING-per tooth	90.00

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

ROOT THERAPY	
Anterior	400.00
Bicuspid	450.00
Molar	650.00

For services provided by a board Endodontists:

ROOT THERAPY	
Anterior	450.00
Bicuspid	500.00
Molar	700.00
RETREATMENT OF ROOT THERAPY	
Anterior	500.00
Bicuspid	650.00
Molar	800.00

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 or Immediate	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

	Plan Pays
Endosteal/Subperiosteal/Transosseous Implant	1,200.00
Prefabricated Abutment	475.00
Custom Abutment	475.00
Interim Abutment	300.00
Abutment Supported Porcelain Ceramic Crown	700.00
Abutment Supported Porcelain/Metal Crown	700.00
Abutment Supported Crown	600.00
Abutment Supported Cast High Noble Metal Crown	700.00
Implant Supported Porcelain Ceramic Crown	1,000.00
Implant Supported Porcelain/High Noble Metal Crown	1,000.00
Implant Supported High Noble Metal Crown	1,000.00

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..... 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 twice 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 twice per thirty-six months

ORTHODONTICS
$3,600 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

VISION CARE EXPENSE BENEFITS

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 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

Service	**Maximum Payment**
Eye Examination	
Without ophthalmologic tests	10.00
With ophthalmologic tests	20.00
Lenses:	
Each single vision lens (including cosmetic contact lens)	15.00
Each bi-focal lens	20.00
Each tri-focal lens	25.00
Each lenticular lens	45.00
Frames	40.00

EXCLUSIONS – The following services are not covered:

1. Services and materials:

   (a) In connection with special procedures such as orthoptic 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 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.

VISION CARE PARTICIPATING PROVIDER OPTION

Provides 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 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.

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).

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 an Active 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 Panarnic, 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.

ACTIVE 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 current listings of vision center locations.

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

HOSPITAL INCOME BENEFITS

BENEFITS: The Hospital Income Benefits Plan will pay covered Members or their eligible dependents up to $50 per day, for up to a maximum of 70 days in a calendar year, for a hospital confinement ordered by a physician as the result of an accident or sickness, including pregnancy.

EXCLUSIONS:

No benefits will be payable for:

1. A dependent confined to a hospital on the date that coverage under this Plan would normally start. Such dependent will not be covered until given a final release by the doctor for such confinement.

2. The day of discharge from the hospital.

3. Confinements due to alcoholism, substance abuse, drug addiction, mental illness or functional nervous disorders.

4. Confinements due to an act of war or while on full-time Active Military Duty.

5. Hospital stays for dependent children prior to January 1, 2005.

Note: This benefit may not be assigned to any third party, including the hospital.

HOW TO FILE A CLAIM: After your hospital confinement, you must complete all items (Member Information, Spouse Information, Physician Information, and Authorization to Release Information) up to the Certification of Confinement portion of the Hospital Income Claim Form. Either the hospital or your attending physician must complete the Certification of Confinement.

Completed claim forms, which must be accompanied by: (1) a copy of a hospital bill including the patient's name and dates of confinement, and (2) a copy of the Explanation of Benefits Statement 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

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. Hospital Income 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.

NEW DEPENDENT BENEFIT

BENEFITS: The New Dependent allowance is a benefit payable in all cases where a child is born to a Member. The Fund will reimburse $2000 for each child born to or adopted by the Member to help defray the costs of a new dependent. This benefit is not available to be assigned to any hospital or medical care provider.

HOW TO FILE A CLAIM: After the birth, the Member must complete all items (Patient Information, 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 *a copy of the birth certificate for your newborn child and receipts reflecting your additional expenses.*

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 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. This benefit is secondary to the Hearing Aid benefits available through your major medical carrier.

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, 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 Active Members or any Active Member who retired during the calendar year and who incurred $700 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 Active Member**.*

HOW TO FILE A CLAIM: After you have accumulated $700 in expenses, you must complete all the items of the Health & Wellness Benefit Claim Form.

Eligible benefits include:

- OPTICAL/DENTAL EXPENSES (over and above that which is already covered by the Fund) - up to $600 per plan year;

- WEIGHT LOSS PROGRAMS (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 $700 per plan year;

- FITNESS PROGRAMS (can be individual classes or gym membership; evidence of attendance is required) - up to $700 per plan year;

- LIFE INSURANCE PREMIUMS - up to $700 per plan year; and/or,

- CANCER, SICKNESS OR ACCIDENT INSURANCE PREMIUMS (Non-Auto) - up to $700 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 prescription drug 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 while an Active Member. If you die while an active Member, your eligible survivors, who are your lawful spouse or enrolled 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 Member's death.

What are the benefits?

- **Health Plan COBRA premium reimbursement**. In the event of a Member's death, the Security Benefits Fund will reimburse the Member's eligible survivors for the first twelve months of their COBRA premiums for the continuation of basic medical coverage at a cost not to exceed the cost of the health coverage provided by the City of New York.

- **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 Member's date of death for Hospital Income and New Dependent Benefits.

How are benefits obtained?

A Member of the family or named beneficiary of the deceased should notify the Fund Administrator of the Fund's Third-Party Administrator, Administrative Services Only, Inc. of the death of the Member and request the survivor benefits form. The form must be returned to the Fund office and include a certified copy of the Member's death certificate. The Security Benefits Fund will reimburse the eligible survivors for COBRA payments once evidence is furnished that the payments have been made for continuation of the health plan.

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").**

MEMBER ADVOCACY SERVICE

WHAT IS THE MEMBER ADVOCACY SERVICE?

The Security Benefit Fund has arranged for a **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 Members of the ADW/DWA Security Benefit Fund, is a unique program designed to help guide 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 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 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 “Member Advocacy Form”.

Complete the Patient, 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

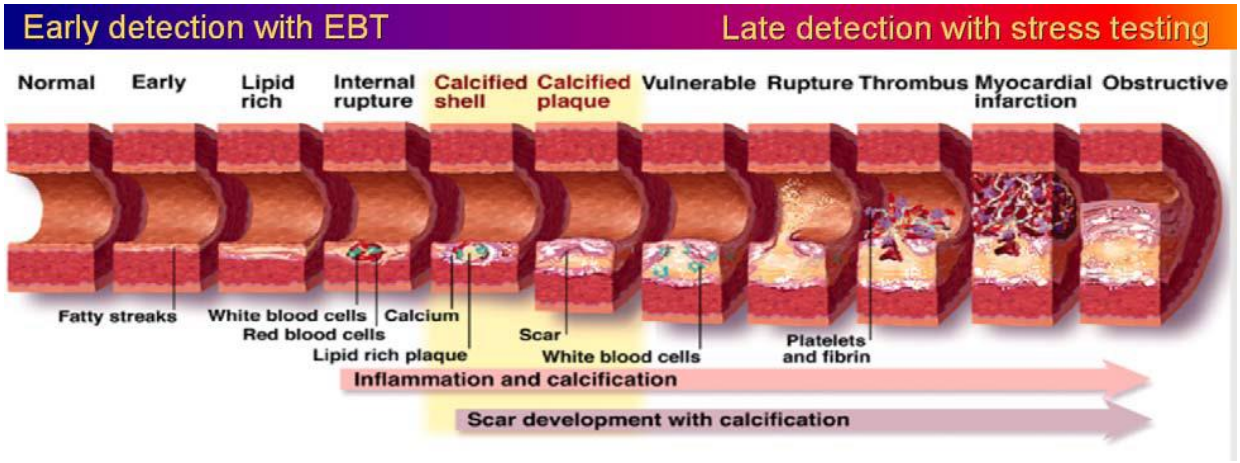
PLEASE NOTE: Administrative Services Only, Incs does not guarantee that the Medical Advocacy Service will resolve your problem to your satisfaction. Your basic health plan insurance contract and the administrative practices and internal controls of the insurance company will determine the outcome of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

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:

EXAM	MEMBER FEE	ADWDWA BENEFIT	TOTAL COST
Heart & Lung Screening	$50.00	$300.00	$350.00
Heart – Lung – Abdomen – Pelvis (Full Body)	$75.00	$300.00	$375.00
Virtual Colonography (VC)	$125.00	$300.00	$425.00
Nuclear Stress Testing (A medical insurance covered test)	$15.00 (copay)	$0.00	$15.00

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 drivers license.

FUNERAL BENEFIT

BENEFITS: The Funeral Benefit has been established to help offset the funeral expenses of eligible dependent children. The $10,000.00 benefit will be payable upon the death of an eligible dependent child up to the age of 19, if the child is a full-time student to the age of 23, 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 Member, the Member's spouse, or a child who is not considered a dependent according to the Fund's eligibility guidelines.

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

Active Members $200,000

Spouse $25,000

Dependent Child(ren)

Live birth to 12 months of age $1,250

12 months to 19 years of age or to 23 years of age (if eligible).....$10,000

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 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.

ACCIDENTAL DEATH, DISMEMBERMENT BENEFITS

This coverage will pay you the full amount shown below if you receive a covered bodily injury with any the following named losses:

- Life
- Both hands or both feet
- Sight of both eyes

Any two or more:

- One foot
- One hand
- Sight of one eye

The losses must (a) be caused by an accident; (b) be the result of the injury, directly and independently of all other causes; and (c) occur within ninety days after the injury.

All benefits other than for loss of life will be paid to the individual. Benefits for loss of life will be paid to the individual's beneficiary.

This coverage will pay you one-half of the amount shown below for loss of:

- One hand; or,
- One foot; or,
- Sight of one eye

Loss of hand or foot means loss by cutting off at, or above the wrist or ankle joint. Loss of sight means total loss that cannot be recovered.

If an individual has more than one loss due to one accident, payment will be made only for the loss with the largest benefit. Payment will be made only for the loss that results from the accident without regard to any former loss.

AMOUNT OF ACCIDENTAL DEATH, DISMEMBERMENT INSURANCE

Active Members $150,000