LEVITTOWN UNITED TEACHERS

HELPING BUILD OUR COMMUNITY
ONE STUDENT AT A TIME

LEVITTOWN UNITED TEACHERS SUPPLEMENTAL BENEFITS FUND

COMPREHENSIVE BENEFITS BOOKLET

Revised September, 2022

LEVITTOWN UNITED TEACHERS SUPPLEMENTAL BENEFITS FUND

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September 1, 2022

Dear Member:

We are pleased to present you with this updated, comprehensive benefits booklet that describes the benefits provided by the Levittown United Teachers Supplemental Benefits Fund (LUTSBF).

Established under the terms of the collective bargaining agreement between the Levittown United Teachers union and the Levittown School District, the LUTSBF provides a plan of benefits for all eligible members of the Levittown United Teachers (LUT) and their dependents. In addition, death and accidental death and dismemberment benefits will be provided for eligible members.

This booklet includes descriptions and details about all LUTSBF benefits including enrollment, eligibility, coverage for dependents, and general information concerning LUTSBF procedures. To the extent that this booklet describes an insured benefit, the group insurance contract specifies the exact benefits provided, and the language of the insurance contract will govern in the event of inconsistency between the language in the insurance contract and the language contained in this booklet.

Effective September 1 of 2022, the LUTSBF made significant improvements to the Fund's Optical Benefit. A full explanation of these improvements can be found starting on page 29 of this booklet.

Effective March 1 of 2022, the LUTSBF began providing a hearing aid benefit to eligible LUT members and their dependents. A full explanation of the hearing aid benefit can be found on page 58 of this booklet.

We urge you to read this booklet carefully and to become familiar with the all available LUTSBF benefits. Should you have any questions, please contact the LUTSBF Office using the contact information provided on page 2 of this booklet.

In Unity,

BOARD OF TRUSTEES

John Caulfield, Chairperson
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GENERAL INFORMATION

ELIGIBILITY

For Employees/Covered Members

You are a covered "member", eligible for coverage under the Levittown United Teachers Supplemental Benefits Fund ("Fund") if you are employed by the Levittown Public School District in a position covered by the Levittown United Teachers' Bargaining unit and for whom contributions are or should have been made to this Fund pursuant to collective bargaining.

Your coverage became effective on September 1, 1977 provided you were employed on that date and contributions were made on your behalf as required by the collective bargaining agreement between the Union and the District. You will continue to be eligible for benefits while you are employed.

For Members hired or rehired after September 1, 1977 your eligibility will begin on the first of the month following the date you are placed on the payroll of the District.

Eligible Dependents

Eligible dependents include:

- Your spouse to whom you are legally married;

- Your unmarried dependent children until the end of the month in which they reach their 19th birthday. Dependent children are your natural children, stepchildren, legally adopted children, including children in a waiting period prior to finalization of adoption, and any other children related to you by blood or marriage who are living in a regular parent-child relationship with you and are chiefly dependent upon you for financial support and maintenance. To establish the eligibility of a stepchild or any other child related to you by blood or marriage, a member must submit an affidavit verifying that said child resides full-time with the member and proof of financial dependency as shown by income tax returns. This affidavit is available at the Fund Office.

- Unmarried dependent children who are full-time students at an accredited educational institution and have not reached their 25th birthday. An unmarried child who is a full-time student will be covered up to age 25 if he/she is enrolled for no less than 12 undergraduate credit hours or 6 graduate credit hours per semester. Student verification must be submitted to the Fund before a claim can be honored. This must be done each semester and can usually be provided from your child's college to verify enrollment.

- Your unmarried children, regardless of age, who are incapable of self-sustaining employment by reason of mental or physical handicap and become so prior to their attaining age 19 and further provided that such children reside with a covered member and are wholly

dependent on the covered member for support. You must submit proof of your dependent child's incapacity to the Fund no less than 31 days prior to the date he or she will attain the age at which his or her coverage would otherwise terminate or within 31 days after you are notified of his or her ineligibility, whichever is later. Proof of the continued existence of such incapacity shall be furnished to the Fund from time to time at its request.

Coverage for eligible dependents will begin:

a) For members hired before September 1, 1977, effective September 1, 1977;

b) For members hired or rehired after September 1, 1977, the first of the month following the date you are placed on the District's payroll; or

c) For new dependents, on the day they become eligible, once the member's new dependent(s) are enrolled by you and the appropriate form is completed and accepted by the Fund office.

Subject to enrollment, your eligible dependents will receive certain benefits outlined in this booklet.

Termination of Eligibility for Coverage

Your coverage will stop at the end of the month in which a member leaves employment for any reason and District contributions are not being paid to the Fund or a dependent no longer qualifies as a dependent as defined above.

Reinstatement of Eligibility

If a member loses eligibility, eligibility will be reinstated for all benefits when he or she is rehired as a covered member and contributions are made on his/her behalf by the District.

ENROLLMENT – REQUIRED FOR BENEFITS

In order to insure your continued eligibility for benefits you must complete the Fund's Enrollment Card and send it to the Fund Office either directly or through your Union representative. No benefit payments will be made unless your signed Enrollment Card has been received and filed at the Fund Office, since it is used to verify your status in the Fund when you submit a claim for benefits.

Annual Opt-Out Requirement for Dental and Optical Benefits

Federal law requires that the Fund provide an opportunity for members to "opt-out" of coverage for their dental and optical benefits offered by the Fund. Once you and/or your eligible dependents are duly enrolled for benefits from the Fund, you will continue to be covered unless you "opt-out" of coverage, in writing, to the Fund. If you wish to continue your eligibility for dental and optical benefits, which will continue uninterrupted, you need to do nothing.

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 in its sole discretion. 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/or your dependents' coverage will stop on the earliest of the following dates:

- When the Fund is terminated.
- When you are no longer eligible.
- When the Employer ceases to make contributions on your behalf to the Fund.
- Your dependents' coverage will terminate when you cease to make contributions on behalf of your eligible dependents 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 sole 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 sole prudent discretion at any time without legal right or recourse by a member or any other person.

RIGHT TO APPEAL

The benefits provided by this Fund may be changed by the Board of Trustees in their sole and absolute discretion. 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 may request a review of action by submitting notice in writing to the Board of Trustees within 60 days after the action of the Fund Office at the following address:

Levittown United Teachers Supplemental Benefits Fund
c/o Fund Director
150 Abbey Lane, Suite 202
Levittown, New York 11756

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.

CLAIMS FILING PROCEDURES

Filing of Claims

All claims for benefits must be submitted on claim forms made available by the Fund Office or the applicable Insurance Carrier. Members must pick up claim forms at the Fund Office or call the Fund Office and request that a claim form be mailed to them. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. All vision claims must be submitted within 90 days of the date expenses were incurred. All dental claims must be submitted within 12 months of the date of service. For claims processed on long term disability benefits see pages 30-33.

For additional claim procedures for the vision care benefits, see page 29.

COORDINATION OF BENEFITS

In the event that a person covered by the Fund is covered under another group health 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 Fund, then the 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.

BENEFITS PAYABLE ON BEHALF OF DECEASED MEMBER

With respect to any benefits (except for the Fund burial benefit) 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;

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

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

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

The Fund has the right to recoup overpayments as a result of 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.

NOTICE OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the Levittown United Teachers Supplemental Benefit 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 previously distributed to all members 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 disclose protected health information for employment-related actions and decisions.

CONTINUATION OF COVERAGE

A. STATUTORY CONTINUATION

1. COBRA CONTINUATION COVERAGE

Federal law requires that most group health plans (including the Levittown United Teachers Supplemental 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, and the eligible 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.

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 Levittown Public Schools, 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 Levittown Public Schools, 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.

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 Office Manager 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.

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 Director 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 Director of that fact within 30 days after SSA's determination.

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 Director within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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 consider 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 consider 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.

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.

For more information

If you have any questions concerning COBRA continuation coverage, you should contact the Fund office at Levittown Memorial Education Center, 150 Abbey Lane, Suite 202, Levittown, New York 11756 or by calling (516) 796-5660.

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.)

Keep Your Plan Informed of Address Changes

In order to protect you 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 Director.

2. CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) entitles eligible employees of the District with up to twelve (12) weeks of family leave in a twelve (12) month period to care for a dependent child, covered family members or for the serious illness of the employee. If you take a FMLA leave, the District must continue to contribute to the Fund on your behalf and certain health-related benefits through the Fund must continue. If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation of coverage. Upon submission by the District to the Fund of documentation verifying your FMLA status, the Fund will provide benefits during the FMLA period.

B. NON-STATUTORY CONTINUATION OF COVERAGE

1. DEATH OF A MEMBER

The eligible dependents of a deceased member will remain eligible for DENTAL BENEFITS ONLY until the August 31st after the death of that member.

DENTAL BENEFITS PLAN

This Plan is designed to encourage the prevention of dental problems by helping to pay the cost of regular visits to the dentist. And, should they occur, the Plan will help pay the expense of major dental services when they are needed.

Who is Eligible? - Members and eligible dependents

When Does Your Coverage Become Effective?

On your date of eligibility if then actively at work; otherwise, on the day you return to active work.

When does Coverage End?
The coverage provided by this Plan will terminate at the end of the month in which a member leaves employment for any reason, including retirement.

However, if a member loses coverage because of a termination of employment for any reason, coverage can be reinstated for all benefits when he or she is rehired as a member, on a full time basis in a position for whom contributions from the District are required to be made to this Fund.

What are the Dental Plan Benefits?

PLAN MAXIMUMS
Effective with all covered dental services rendered on or after July 1, 2021, the plan year maximum amount payable for expenses incurred each plan year for covered dental procedures is $2,125 for each individual covered under the Plan. A plan year is defined as the 12-month period beginning each July 1st and ending June 30th. There is no limit on what you may receive during your lifetime.

DENTAL IMPLANTS
For eligible dental implant services commenced on or after March 1, 2022, the Fund will cover up to 4 dentally necessary dental implants per covered individual per lifetime. This maximum is not included in the yearly dental maximum of $2,125.

Reimbursement for dental implants will only be made under the applicable ADA procedure codes in the 6000 series (or otherwise, as determined by the ADA) and for four per lifetime per covered person. See Schedule of Covered Dental Allowances for more detail.

ORTHODONTIC BENEFITS
Effective for eligible, covered services that begin on or after March 1, 2022, adult orthodontia for members and their eligible spouse/domestic partners are covered. The Adult Orthodontia Benefit lifetime maximum is $2,050.

Effective March 1, 2022, the orthodontic lifetime maximum is increased to $2,550 per covered and enrolled eligible dependent children of members.

Invisalign services, if rendered by an authorized Invisalign provider, are covered under the Orthodontia Benefits described above.

OTHER PROVISIONS

Alternate Benefit Provision for Dental Procedures

Often there are several ways to treat a particular dental problem. For example, either a crown or a filling can perform equally well in certain situations. The same holds true in a decision about the use of precious metals versus amalgam. Before the alternate procedures provision is used, the dental consultant reviews the claim to verify that an alternate method of treatment would meet professional standards. If so, the payment is based on the least costly amount so long as the results meet accepted standards of dental practice.

If the member and their dentist agree on the more costly treatment, the member is responsible for paying the excess amount over the benefits allowed for the least costly appropriate treatment.

ADDITIONAL PROVISIONS

1. Charges for dentures (including bridges and crowns) are included as covered dental expenses only if the dentures are ordered and fitted while the individual's coverage is in force and are delivered to the individual prior to the date coverage is terminated or within 31 days thereafter.

2. Charges for Major Restorative Procedures, are involved for the installation of fixed bridgework, removable dentures (partial or full) crowns or inlays, the plan would provide for:

    a) Initial installation of fixed bridge work or removable dentures (partial or full).
    b) Replacement of or additions to bridgework, dentures, crowns or inlays including re-cementing where necessary because:
    (i) one or more teeth were extracted after the existing denture of bridgework was installed, or
    (ii) the existing denture or bridgework was installed at least 5 years prior to its replacement and cannot be made serviceable, or
    (iii) the existing denture is temporary and a permanent denture is installed within 12 months from the date of the initial installation of the temporary denture.

What Dental Expenses Are Not Covered?

1. Expenses for services rendered prior to the effective date of the individual's coverage.

2. Expenses for surgery or treatment for cosmetic purposes, except that expenses for such surgery or treatment required for correction of damage caused by accidental injury sustained while coverage is in force shall not be excluded if they otherwise qualify as "Covered Dental Expenses". This benefit is secondary to any coverage the patient might receive under his/her basic medical benefits.

3. Expenses for services received because of dental injury arising out of or in the course of any employment for wage or profit, or dental disease or defect entitling the individual to benefits under any workers' compensation or occupational disease law.

4. Expenses for services to the extent that such services, or benefits for or because of such services, are available under any governmental plan. In the case of any person who is not enrolled for any coverage for which he has become eligible under any governmental plan, services and benefits available under the governmental plan will nevertheless include any benefits to which he would be entitled if he were enrolled for any such coverage. This provision is subject to any governmental requirement that insurance benefits be used before governmental plan benefits are available.

5. Expenses for services received as a result of dental disease, defect or injury due to an act of war, declared or undeclared, unless such act occurred prior to the effective date of the individual's Dental benefits' eligibility.

6. Expenses for services for which charges would not have been made if no dental benefits plan existed or for which there is no cost to the person receiving them.

7. Expenses for dentures, bridges, and crowns and their fitting which were ordered prior to the effective date of the individual's eligibility for this dental plan.

8. Expenses for repair or replacement of dentures or bridgework except those included under "Covered Dental Expenses".

9. Expenses for replacement of lost or stolen dentures.

10. Expenses to the extent of benefits provided for dental care or treatment by any other group plan or prepayment Plan or plan which the employer contributes to or sponsors.

How Do I File a Dental Claim?

All claim forms needed to file for benefits under the dental program can be obtained from the Fund Office. Answers to your questions about the benefits or assistance in filing claims can also be obtained there.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Can I Obtain a Pre-Treatment Estimate?

Yes. Simply follow the instructions below to receive an estimate of the benefits payable by the Fund for the proposed dental work before the work begins. Remember, however, that payment by the Fund is subject to the patient's eligibility for benefits at the time services are rendered, including the application of plan maximums and frequency limitations, e.g.

These are the steps you would follow:

a. Complete and sign the Member Section (Part A) of the claim form and give it to your dentist.
b. The dentist should check the box entitled "Pre-Treatment Estimate of Charges". The dentist should describe his plan of treatment and indicate the charge for each procedure (Part B). Claim forms should be sent to the dental plan administrators , Administrative Services Only, Inc. "(ASO") at P.O. Box 9005, Lynbrook, NY 11563-9005. If you or your dentist has any questions about the pre-treatment estimate process, you may contact ASO at 516-396-5500.

ASO will review the description of procedures and the estimate of the Dentist's charges. A pre-determination of benefits explanation estimating the benefits payable under the plan will be sent to you. You may elect to start treatment. When the dentist completes the work, the date the service was performed should be indicated, the form must be signed by both you and your dentists and to returned to ASO for payment.

A Pre-treatment estimate will remain valid for a period not exceeding one-year from the date of the estimate. However, the claim will be adjudicated according to the benefits in effect at the time the service is received, not as of the date of the pre-treatment estimate. 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.

If you should receive services outlined in the pre-treatment estimate after the one-year period, then the pre-treatment estimate will not be binding on the plan.

When is Pre-Treatment Authorization Required?

Pre-treatment authorization is required for inlays, crowns, laminate veneers, bridges, dentures, periodontal surgery or when the proposed services will exceed $500 in a ninety (90) day period. To obtain pre-treatment authorization, you must submit pre-operative x-rays for inlays, crowns, bridges, dentures, periodontal surgery, root therapy and non-routine extractions. X-rays of the full arch is required for all bridgework. Post-treatment x-rays will also be required for all root canal therapy and implant claims.

LEVITTOWN UNITED TEACHERS
SUPPLEMENTAL BENEFITS FUND
SCHEDULE OF COVERED DENTAL ALLOWANCES

DIAGNOSTIC & PREVENTIVE

	Plan Pays	Network Copay
ORAL EXAMINATION - *maximum-two in a plan calendar year*	30.00	
X-RAYS- *maximum $60 any combination in any 12 consecutive months*		
PANORAMIC FILM	50.00	
FULL MOUTH SERIES X-RAYS	60.00	
INTRAORAL FILM		
Periapical or bitewing, per film	6.00	
OCCLUSAL FILM	15.00	
CEPHALOMETRIC FILM	40.00	
PROPHYLAXIS, including scaling and polishing- *maximum-two in a plan year*		
adult	55.00	
child, to age 15	40.00	
FLUORIDE TREATMENT- *maximum-one in a calendar year*		
child, to age 16	20.00	
SEALANTS - *lifetime maximum-1 application per tooth*		
child, to age 16, *unrestored permanent posterior teeth*	20.00	
DIAGNOSTIC CASTS	26.00	
SPACE MAINTAINER	250.00	50.00
ADJUNCTIVE PRE-DIAGNOSTIC TESTING*	35.00	

**Effective for services rendered on or after March 1, 2022. Minimum age 40-Once per 24 months*

BASIC RESTORATIVE

SILVER AMALGAM FILLINGS		
one surface-	70.00	
two surfaces-	80.00	
three surfaces-	90.00	
four or more surfaces-	100.00	
COMPOSITE RESIN-anterior or posterior		
one surface	70.00	
two surfaces	90.00	
three or more surfaces	100.00	
four or more surfaces involving the incisal angle	115.00	
PIN RETENTION-per tooth	75.00	
PORCELAIN\METALLIC INLAY-once per 60 months		
One surface	150.00	50.00
two surfaces	300.00	50.00
three or more surfaces	350.00	50.00
PORCELAIN\METALLIC ONLAY-once per 60 months		
One surface	220.00	50.00
two surfaces	370.00	50.00
three or more surfaces	420.00	50.00

MAJOR RESTORATIVE

	Plan Pays	Network Copay
CROWNS		
Resin based	275.00	75.00
Porcelain/ceramic	300.00	75.00
porcelain with metal	425.00	75.00
full or 3/4 cast	325.00	75.00
PORCELAIN LAMINATE	400.00	100.00
STAINLESS STEEL CROWN, primary tooth	100.00	
POST & CORE-pre-fabricated-once per 60 months	150.00	25.00
POST & CORE-cast once per 60 months	200.00	25.00
CROWN BUILD-UP* once per 60 months	75.00	

**Effective for services rendered on or after March 1, 2022.*

ENDODONTICS

x-ray evidence of satisfactory completion required

PULP-CAP, direct	50.00	
PULPOTOMY	150.00	
APICOECTOMY, 1st root	300.00	100.00
APICOECTOMY, maximum per tooth	500.00	100.00
RETROGRADE FILLING-per tooth	85.00	
ROOT CANAL THERAPY		
Anterior	375.00	50.00
Bicuspid	425.00	50.00
Molar	500.00	50.00

PROSTHODONTIC REPAIRS

DENTURE RELINE		
office procedure-complete	150.00	50.00
office procedure-partial	150.00	50.00
laboratory procedure-complete	200.00	50.00
laboratory procedure-partial	200.00	50.00
DENTURE REPAIRS		
denture adjustment	100.00	25.00
repair cast framework	125.00	25.00
broken denture base	100.00	25.00
replace tooth or broken clasp in denture	100.00	
replace broken facing	100.00	
add tooth or clasp to existing partial denture	100.00	
RECEMENT CROWN	50.00	
RECEMENT SPACE MAINTAINER	50.00	
RECEMENT BRIDGE	100.00	

PROSTHODONTICS

	Plan Pays	Network Copay
COMPLETE DENTURE		
Immediate or Permanent	600.00	50.00
PARTIAL DENTURE-unilateral	300	
PARTIAL DENTURE-bilateral		
acrylic base with clasps and rests	425.00	
cast metal base	700.00	
PRECISION ATTACHMENT	200.00	
BRIDGE ABUTMENT		
porcelain fused to metal	425.00	75.00
resin with metal	325.00	75.00
crown-full cast or ¾ cast	325.00	75.00
MARYLAND BRIDGE RETAINER	300.00	50.00
BRIDGE PONTIC		
full cast	325.00	75.00
resin with metal	325.00	75.00
porcelain with metal	425.00	75.00
IMPLANTS - limited to *four implants per lifetime.		
Endosteal implant (not subject to annual maximum)	600.00	600.00
prefabricated/custom abutment (not subject to annual maximum)	250.00	250.00
abutment supported crown	375.00	375.00
implant supported crown	475.00	475.00

**Effective for services rendered on or after March 1, 2022.*

ORAL SURGERY

EXTRACTION ERUPTED TOOTH	125.00	25.00
SURGICAL EXTRACTION - *must be demonstrated by x-ray*		
erupted tooth requiring removal of bone or sectioning	150.00	50.00
retained root	150.00	50.00
impaction-soft tissue	275.00	75.00
impaction-partial bony	350.00	75.00
impaction-complete bony	425.00	75.00
SURGICAL EXPOSURE – IMP/UNERUP (AID ERUPTION)	200.00	100.00
SURGICAL EXPOSURE – IMP/UNERUP (FOR ORTHO)	200.00	100.00
ALVEOLOPLASTY-*maximum per quad*	125.00	50.00
FRENULECTOMY	100.00	25.00
BIOPSY OF ORAL TISSUE	100.00	50.00
REMOVAL OF CYST OR TUMOR <1.25CM	125.00	50.00
REMOVAL OF CYST OR TUMOR >1.25CM	150.00	50.00
INCISION & DRAINAGE **-** *no other treatment that visit*	50.00	
ROOT RESECTION/HEMISECTION	250.00	
GENERAL ANESTHESIA/IV SEDATION- *per 15 minutes (max 30 minutes)*	90.00	

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.

	Plan Pays	Network Copay
ROOT SCALING, and BITE CORRECTION, including prophylaxis, per quad maximum 2 quadrants per day	50.00	10.00
PERIODONTAL MAINTENANCE -	90.00	
Maximum payment for any combination of -$180 per plan 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	250.00	100.00
OSSEOUS SURGERY per quadrant	525.00	100.00
PEDICLE SOFT TISSUE GRAFT	250.00	100.00
FREE SOFT TISSUE GRAFT	250.00	100.00
OSSEOUS GRAFT PER SITE	165.00	50.00
OSSEOUS GRAFT ADDITIONAL SITE	85..00	50.00
OSSEOUS GRAFT MAX PER QUADRANT	250.00	100.00

ORTHODONTICS

- **$2,550 lifetime maximum per covered and enrolled eligible dependent child**
- **$2,050 lifetime maximum per eligible member and their eligible spouses/domestic partners for adult orthodontia**

HARMFUL HABIT APPLIANCE	270.00	
DIAGNOSIS AND INITIAL ORTHO APPLIANCE	300.00	300.00
ACTIVE TREATMENT PER MONTH	50.00	25.00
PASSIVE TREATMENT PER 3 MONTHS max 9 months	50.00	25.00
RETENTION APPLIANCE	200.00	50.00

ADJUNCTIVE SERVICES

SPECIALIST CONSULTATION- *including an oral examination*	65.00	25.00
PALLIATIVE TREATMENT- *no other treatment that visit*	50.00	25.00

INVISALIGN SERVICES – covered under orthodontia benefit described above if rendered by an authorized provider.

LIFE INSURANCE BENEFIT

Effective July 1, 2017, the group life Insurance benefit is underwritten by First Reliance Standard Life Insurance Company ("Company"). Please refer to the Certificate of Group Life Insurance for more complete details as to the Life Insurance Benefit.

Who is Eligible?

Each Active, Full-Time Teacher and Teacher Assistant in the collective bargaining unit of Levittown United Teachers, who is working for Levittown Public Schools ("District") and for whom the District makes contributions to the Fund.

What is the Benefit?

All active members **who work full-time** are covered by a life insurance policy with a face value of $20,000 ("Life Amount" or "Principal Sum"). This amount is reduced by 50% on the date you reach age 70 years old, provided you are still actively working for the District and covered by this Fund. The Life Amount will be reduced by any benefit paid under the Accelerated Benefit Rider (see below for details).

In addition, each member is eligible for Accidental Death & Dismemberment insurance of up to $20,000.

The First Reliance Standard Life Insurance Company will pay the Life Insurance benefit to your designated beneficiary, subject to the terms and conditions of the Policy, in the event of your death while insured.

No Medical Examination

No medical examination is required to secure this coverage.

Change of Address or Status

In the event that you change your address or there is any change in your mental status or number of dependents, you should notify the Fund Office at once to insure the continuing eligibility of you and your dependents for insurance coverage.

Beneficiary Designation: How do I designate or change my beneficiary?

You may designate or change a beneficiary by doing so in writing on a form satisfactory to the Insurance Company and filing the form with the Fund or Company. Only satisfactory forms sent to the Fund prior to Your death will be accepted. If You name more than one beneficiary and do not specify the amounts, percentage shares, or order of payment, benefits payable will be divided equally among all beneficiaries. If the beneficiary dies at the same time as you, or within fifteen (15) days after your death but before we received written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise. If you have not named a

beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

(1) your legal spouse;
(2) your surviving child(ren) (including legally adopted child(ren)), in equal shares;
(3) your surviving parents, in equal shares;
(4) your surviving siblings, in equal shares; or if none of the above,
(5) your estate.

If You have designated an irrevocable beneficiary, You will be able to change that beneficiary only after the Company has received a signed release from Your irrevocable beneficiary.

What is Required to File a Claim?

When the life insurance company determines that benefits are payable, it will pay benefits in accordance with the Claims Provisions section of the Policy, summarized below. Written notice of death must be sent to the Company within 30 days the Loss occurs or as soon as reasonably possible. Proof of Loss must be sent to the Company within 90 days, when possible, but in no event later than one year, and may include, but is not limited to, the following:

(1) a completed claim form
(2) a certified copy of the death certificate (if applicable)
(3) Your Beneficiary Designation (if applicable)
(4) Any additional information required by the Fund and/or Insurance Company to adjudicate the claim.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the procedures set forth more fully in the Policy to:

First Reliance Standard Life Insurance Company
Quality Review Unit
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532.

A copy of any Appeal submitted to the Insurance Company should be provided to the Fund Office.

What are the Policy's Exclusions

The Policy does not cover any loss :

(1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
(2) caused by suicide or intentionally self-inflicted iinjuries; or
(3) caused by or resulting from war or any act of war, declared or undeclared; or
(4) caused by an accident that occurs while in the armed forces of any country, except when participating in the Reserve or National Guard on inactive duty status; or

(5) caused by or resulting from riding in, getting into or out of any aircraft, unless: (a) the Insured Person is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and (b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured Person, or any other employer of the Insured Person, unless a specific written agreement has been obtained from the Company; or

(6) sustained during the Insured Person's commission or attempted commission of a felony; or

(7) caused by the Insured Person's alcoholism.

What is the Accelerated Benefit?

The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the insured under the Policy on the date of the Certification of Terminal Illness. This benefit may be paid as a single lump sum or in installment payments, mutually agreed to by the Company and the insured. Each payment will equal 25% of the total Accelerated Benefit. Once the Accelerated Benefit has been paid for any Insured, no additional Accelerated Benefit is payable for that Insured. And, the Accelerated Benefit will reduce the amount of the life insurance benefit payable at the time of the Insured's death.

"Terminally Ill" or "Terminal Illness" refers to an Insured's illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 12 months.

In order for this benefit to be paid:

(1) the Insured must make a Written Request; and

(2) the Company must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

Conversion Right: If coverage under The Policy ends or is reduced, do I have a right to convert?

If Life Insurance coverage or any portion of it under The Policy ends due to termination of employment or membership in the LUT, You have the right to convert the coverage that terminated to an individual conversion policy without providing proof of health. You must make written applicable for the policy within thirty-one (31) days after you terminate.
If the insurance ceases due to the termination or amendment of the Policy, you also have the right to convert to an individual life insurance policy. However, the face amount will be less any amount you are entitled to under any other group life policy issued or reinstated by the Company or another insurance company within forty-five (45) days after the date insurance coverage ceases.

Conversion is not available for any Amount of Life Insurance for which You were not eligible and covered under The Policy.

See the Certificate of Insurance for further details.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Who is Eligible? – Active Employees Only

***What is the Accidental Death and Dismemberment Benefit*?**

If, due to Injury, the Insured Person suffers any one of the following specific Losses within 365 days from the date of accident, the Insurance Company will pay the Benefit Amount listed below. In order to be eligible for benefits for Total Loss of Use of limbs such loss must continue for a period of 12 consecutive months after the onset and must be shown by proper medical authority at the end of such 12 months that Total Loss of Use has been continuous and will be permanent. However, if more than one listed loss results from any one accident, the Company will only pay the one largest applicable benefit as listed below. In no event will the total of all benefits paid for any one Insured Person for any one accident under this benefit exceed that Insured Person's Principal Sum.

Loss	**Benefit Amount:**
Loss of Life…….…….	100% of the Insured Person's Principal Sum
Loss of Two or Moore Members ……	100% of the Insured Person's Principal Sum
Loss of Speech and Hearing ……	100% of the Insured Person's Principal Sum
Loss of One Member ……	50% of the Insured Person's Principal Sum
Loss of Speech or Hearing ……	50% of the Insured Person's Principal Sum
Loss of Thumb and Index Finder of the Same Hand ……	25% of the Insured Person's Principal Sum

For Total Loss of Use of:	**Benefit Amount:**
Both Arms and Both Legs ……	100% of the Insured Person's Principal Sum
Both Arms ……	67% of the Insured Person's Principal Sum
Both Legs ……	67% of the Insured Person's Principal Sum
One Arm and One Leg ……	67% of the Insured Person's Principal Sum
Both Arms and One Leg or Both Legs and One Arm ……	75% of the Insured Person's Principal Sum
One Arm or One Leg ……	50% of the Insured Person's Principal Sum

Definitions:
"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

(1) a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;
(2) an eye, Loss means the total and irrecoverable loss of sight;
(3) speech, Loss means the total and irrecoverable loss of the function;
(4) hearing, Loss means the total and irrecoverable loss of the hearing in both ears;

(5) a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.

"Total Loss of Use" means loss of the ability to function because of:

(1) incurable paralysis;
(2) atrophy; or
(3) an arthritic condition resulting directly and independently off all other causes from an Injury.

In addition. "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.

Seat Belt and Air Bag Benefit:

The Company will pay a sum equal to 10% of the Insured Person's Principal Sum if:

(1) the Insured Person dies as a result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;
(2) a police report establishes that the Insured Person was properly strapped in a Seat Belt at the time;
(3) Loss of Life benefits are payable for the Insured Person's death hereunder.

The Company will pay an additional 5% if the Insured Person is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System.

***What are the Policy's Exclusions*?**

The Policy does not cover any loss :

(1) to which sickness, disease, or myocardial infarction, inclding medical or surgical treatment thereof, is a contributing factor; or
(2) caused by suicide or intentionally self-inflicted injuries; or
(3) caused by or resulting from war or any act of war, declared or undeclared; or
(4) caused by an accident that occurs while in the armed forces of any country, except when participating in the Reserve or National Guard on inactive duty status; or
(5) caused by or resulting from riding in, getting into or out of any aircraft, unless:
(a) the Insured Person is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
(b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured Person, or any other employer of the Insured Person, unless a specific written agreement has been obtained from the Company; or
(6) sustained during the Insured Person's commission or attempted commission of a felony; or
(7) caused by the Insured Person's alcoholism; or
(8) caused by the Insured Person's drug addiction.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the procedures set forth more fully in the Policy to:

First Reliance Standard Life Insurance Company
Quality Review Unit
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532.

A copy of any Appeal submitted to the Insurance Company should be provided to the Fund Office.

VISION CARE BENEFIT

Who is eligible

- Covered members
- Eligible enrolled dependents of covered members (up to two each plan year)

What are the terms and conditions of this benefit

- An allowance up to $225 for each eligible member.
- An allowance of up to $225 for one (1) eligible dependent.
- An additional benefit of up to $175 for a second eligible dependent.
- The benefit is payable no more than once per plan year. The plan year for this benefit begins on September 1 and ends on August 31.

What Vision Care Services are Covered

- Vision examinations by an optometrist
- Purchase of eyeglasses that involve a prescription
- Repair or replacement of eyeglass frames
- Replacement of individual lenses
- Purchase of contact lenses
- Purchase of optical appliances (e.g: patches to protect irritated eyes.)
- Discounts on LASIK procedures offered by General Vision Services (GVS) through QualSight LASIK.

A full description of services and discounts can be found on pages 31 and 32 of this booklet.

How do I File a Claim

1. Direct Payment Method (In-Network): If you or your dependents wish to use a facility with which the Fund has a special payment arrangement, such as GVS, the following steps must be followed:

    a. Contact the Fund Office for a list of professionals and facilities that will accept the Fund's negotiated payment as payment in full.
    b. Obtain a voucher from the Fund Office confirming the eligibility of either yourself or your eligible dependent for this Benefit.
    c. Submit the voucher to the facility that will accept the negotiated Fund payment as payment in full for covered vision care services.
    d. Any special services or goods requested by you or your eligible dependent - including, but not limited to: tinted lenses or special frames - must be paid by you or your dependent.
    e. Payment of the cost of all covered services will be made by the Fund directly to the facility.

2. Reimbursement Method (Out of Network): If you or your dependent(s) wants to receive vision care benefits from a professional or facility other than those with an agreement with the Fund Office, the following steps must be followed:

    a. Obtain a claim form from the Fund Office.
    b. Have professional or facility complete the claim form for all covered services.
    c. Any special services or goods requested by you or your eligible dependent - including, but not limited to: tinted lenses or special frames - must be paid by you or your dependent.
    d. Obtain a bill for covered services provided by the professional or facility.
    e. Submit the completed claim form as well the bill for covered services from the professional or facility to the Fund Office for reimbursement up to the Benefit limits as outlined in this booklet.

LEVITTOWN UNITED TEACHERS
HELPING BUILD OUR COMMUNITY ONE STUDENT AT A TIME

LEVITTOWN UNITED TEACHERS SUPPLEMENTAL BENEFIT FUND MEMBER + ONE DEPENDENT BENEFIT #6268

WELCOME TO YOUR ENHANCED VISION BENEFIT!

You and one dependent are eligible for services on 9/1/2022. Contact your fund office to obtain a valid benefit voucher.

Visit **generalvision.com** and enter benefit number 6268 for more information. Or call 800.VISION.1

ADDITIONAL DISCOUNTS

LASIK DISCOUNT

Save 40% to 50% off* traditional LASIK services with QualSight LASIK at more than 1,000 locations nationwide. Savings also available on newer technologies such as Custom Bladeless (all laser) LASIK.

Call 888-568-0308

for your FREE consultation.

Visit qualsight.com/-gvs for more information.

*Savings based on overall national average price.

HEARING DISCOUNT PLAN

GHS GENERAL® HEARING SERVICES
POWERED BY EPIC

An exclusive National Hearing Care Program that provides affordable services to GVS active and retiree members, as well as their families.

Call 800-480-0558

for more information.

MAIL ORDER CONTACT LENSES DISCOUNT

1800AnyLens

15% Off

Every Contact Lens Purchase

Promotion Code: GVS15OFF

Call: 1-800-ANY-LENS

or Visit: 1800anylens.com

VISION BENEFITS	CO-PAYS	FREQUENCY
EYE EXAMINATION		Every 12 Months
Includes Tonometry	Covered in full	
FRAME ALLOWANCE[1]		Every 12 Months
GVS Collection Frame	$275 Allowance	
Non-Collection Frame	$225 Allowance	
SPECTACLE LENSES		Every 12 Months
Single Vision	Covered in full	
Bifocal	Covered in full	
Trifocal	Covered in full	
Oversize	Covered in full	
Standard Progressive	Covered in full	
Premium Progressive	$80	
Deluxe Progressive	$120	
MATERIALS		
Plastic	Covered in full	
Polycarbonate for dependent children (up to age 16)	Covered in full	
Polycarbonate - Single Vision & Bifocal	$25	
Hi-Index - Single Vision	Covered in full	
COATINGS		
Tints	Covered in full	
Ultra Violet	Covered in full	
Scratch Resistant	Covered in full	
Plastic Photosensitive Lenses (single vision)	$65	
Plastic Photosensitive Lenses (bifocal)	$95	
Polarized - Single Vision	$60	
Anti-reflective - Standard Coating	Covered in full	
Anti-reflective - Premium Coating	$90	
CONTACT LENSES (In Lieu of Eyeglasses)		Every 12 Months
Plan Contact lenses	Up to 12 Month supply	
Plan Contact Lens Evaluation, Fitting & Follow-Up Visits	Covered in full	
Non-Plan Contact Lens (excluding colored)	$225 Allowance	
Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits	$50	
Out of Network Benefit	Up to $225	

GVS GENERAL® VISION SERVICES

LEVITTOWN UNITED TEACHERS
HELPING BUILD OUR COMMUNITY ONE STUDENT AT A TIME

LEVITTOWN UNITED TEACHERS SUPPLEMENTAL BENEFIT FUND SECOND DEPENDENT COVERAGE BENEFIT #6269

WELCOME TO YOUR ENHANCED VISION BENEFIT!

Your second dependent is eligible for services on 9/1/2022. Contact your fund office to obtain a valid benefit voucher.

Visit **generalvision.com** and enter benefit number 6269 for more information. Or call 800.VISION.1

ADDITIONAL DISCOUNTS

LASIK DISCOUNT

Save 40% to 50% off* traditional LASIK services with QualSight LASIK at more than 1,000 locations nationwide. Savings also available on newer technologies such as Custom Bladeless (all laser) LASIK.

Call 888-568-0308

for your FREE consultation.

Visit qualsight.com/-gvs for more information.

*Savings based on overall national average price.

HEARING DISCOUNT PLAN

GHS GENERAL® HEARING SERVICES
POWERED BY EPIC

An exclusive National Hearing Care Program that provides affordable services to GVS active and retiree members, as well as their families.

Call 800-480-0558

for more information.

MAIL ORDER CONTACT LENSES DISCOUNT

1800AnyLens

15% Off

Every Contact Lens Purchase

Promotion Code: GVS15OFF

Call: 1-800-ANY-LENS

or Visit: 1800anylens.com

VISION BENEFITS	CO-PAYS	FREQUENCY
EYE EXAMINATION		Every 12 Months
Includes Tonometry	Covered in full	
FRAME ALLOWANCE		Every 12 Months
GVS Collection Frame	$225 Allowance	
Non-Collection Frame	$200 Allowance	
SPECTACLE LENSES		Every 12 Months
Single Vision	Covered in full	
Bifocal	Covered in full	
Trifocal	Covered in full	
Oversize	Covered in full	
Standard Progressive	Covered in full	
Premium Progressive	$90	
Deluxe Progressive	U&C LESS 30%	
MATERIALS		
Plastic	Covered in full	
Polycarbonate for dependent children (up to age 16)	Covered in full	
Polycarbonate - Single Vision & Bifocal	$30 / $50	
Hi-Index - Single Vision	$60	
COATINGS		
Tints	INCLUDED	
Ultra Violet	INCLUDED	
Scratch Resistant	INCLUDED	
Plastic Photosensitive Lenses (single vision)	U&C LESS 30%	
Plastic Photosensitive Lenses (bifocal)	U&C LESS 30%	
Polarized - Single Vision	$85	
Anti-reflective - Standard Coating	$25	
Anti-reflective - Premium Coating	U&C LESS 30%	
CONTACT LENSES (In Lieu of Eyeglasses)		Every 12 Months
Plan Contact lenses	Up to 9 Month Supply	
Plan Contact Lens Evaluation, Fitting & Follow-Up Visits	INCLUDED	
Non-Plan Contact Lens (excluding colored)	$125	
Non-Plan Contact Lens Evaluation, Fitting & Follow-Up Visits	$50 co-pay	
Out of Network Benefit	Up to $175	

GVS GENERAL® VISION SERVICES

VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFIT

Please refer to the respective Certificates of Group Insurance for more complete details as to Long-Term Disability Insurance available for purchase on a voluntary basis by all covered, full-time members of the Fund.

Who is Eligible? – Active Employees Only (working at least 20 hours per week) for whom the District makes contributions to this Fund.

What is the Benefit?

Monthly benefits are payable by the First Reliance Standard Life Insurance Company, on an insured basis.

Schedule of Insurance:
The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness or pregnancy.

Cost of Coverage:
You must contribute 100% toward the cost of coverage, via payroll deduction.

Eligibility Waiting Period of Coverage:
Since this benefit program is voluntary, and on a self-pay basis, there is no waiting period for eligibility. However, enrollment during periods other than open enrollment periods will require evidence of insurability acceptable to the insurance company.

Elimination Period: 90 day(s)

Maximum Monthly Benefit: $4,500

Minimum Monthly Benefit: The greater of:
1) $100; or
2) 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

Benefit Percentage: 66 2/3%

Maximum Duration of Benefits Table

Age When Disabled	**Benefits Payable**
prior to Age 66 ……	24 months
Age 66 ……	21 months
Age 67……	18 months
Age 68……	15 months
Age 69 and over……..	12 months

Eligibility for Coverage: When will I become eligible?
You will become eligible for coverage on the later of:

1) the Policy Effective Date; or
2) the date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Enrollment: How do I enroll for coverage?
To enroll for coverage You must:

1) complete and sign a group insurance enrollment form which is satisfactory to the Insurance Company. This form can be obtained from the Fund office; and
2) deliver it to the Fund Office.

If You do not enroll within 31 days after becoming eligible under The Policy (e.g., from your date of hire), or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:

1) You must give the Insurance Company Evidence of Insurability satisfactory to it; and
2) You may only enroll:
   a) during an Annual Enrollment Period designated by the Fund; or
   b) within 31 days of the date You have a Change in Family Status.

Evidence of Insurability: What is Evidence of Insurability?
Evidence of Insurability must be satisfactory to the Insurance Company and may include, but will not be limited to:

1) a completed and signed application approved by the Insurance Company;
2) a medical examination;
3) attending Physicians' statements; and
4) any additional information the Insurance Company may require.

All Evidence of Insurability will be furnished at Your expense. The Insurance Company will then determine if You are insurable under The Policy.

Notice of Claim: When should I notify the Company of a claim?
You must give the Insurance Company written notice of a claim within 30 days after Disability or loss occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address and the Policy Number. Upon receipt of your notice, the Insurance Company usually sends the claim form to the Fund office. The Fund office will work with the member in filing his/her claim.

Are Disability Benefits Reduced By Any Other Benefits?

Yes. The monthly disability benefit you receive will be reduced by any wages, salary or other compensation you receive for work or services performed, and by any benefits you are eligible to receive:

- because of your disability or age under the Federal Security Act (Primary Social Security);
- or your dependents are eligible to receive because of your disability or age under the Federal Social Security Act (Dependents Social Security);
- because of your disability or age under the Railroad Retirement Act, any federal, state, county or municipal government disability plan or law;
- under Workers' Compensation or similar legislation;
- under any disability or total and permanent disability provision of any franchise plan;
- under any retirement or pension plan for which the Benefits Fund makes payroll deductions or contributions;
- under any salary continuation plan; and
- under any disability provision of any group or individual no-fault automobile plan. Benefits from Social Security will be based on the level in effect on the date of your disability awards regardless of later changes. However, changes in dependent status after the date of your disability award will be considered in the computation of your Social Security and monthly benefit from this Plan.

Coverage while Disabled: Does my insurance continue while I am Disabled and no longer an Active Employee?

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) during the Elimination Period while You remain Disabled by the same Disability; and
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium: Am I required to pay premiums while I am Disabled?

No premium will be due for You:

1) after the Elimination Period; and
2) for as long as benefits are payable.

What happens if I Recover but become Disabled again?

Periods of Recovery during the Elimination (waiting) Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than one-half (1/2) the number of days of Your Elimination Period. Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become disabled and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 6 months of the return to work.

The Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If you return to work as an Active Employee for 6 months or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Exclusions: What Disabilities are not covered?

The Policy does not cover, and the Insurance Company will not pay a benefit for, any Disability:

1) that is caused or contributed to by war or act of war, whether declared or not;
2) caused by Your commission of or attempt to commit a felony;
3) caused or contributed to by Your being engaged in an illegal occupation; or
4) caused or contributed to by an intentionally self-inflicted injury.

COMPREHENSIVE LEGAL SERVICES BENEFITS

"(The assistance of counsel) is one of the safeguards of the Sixth Amendment deemed necessary to ensure fundamental human rights of life and liberty . . . The Sixth Amendment stands as a constant admonition that if the constitutional safeguards it provides be lost, justice will not still be done."

- *United States Supreme Court Justice Hugo Black*
Gideon v. Wainwright

ELIGIBILITY

Covered members, as determined by the Levittown United Teacher Supplemental Benefits Fund, are eligible for legal services plan benefits as described herein.* In general, subject to the requirements pertaining to the definition of a covered member, members are eligible for benefits as long as they are in active payroll status. Active payroll status means the period for which contributions are required to be made on your behalf.

Your eligibility for benefits is terminated as of the effective date your employment is terminated, except as noted below. Should a legal procedure be in progress at the time of the termination, any costs incurred after that date would be your responsibility.

**Please note the Fund must, at this present time, confine the plan benefits to covered members/employees only, except in the case of the Will Benefit, Living Will/Health Care Proxy Benefit, Arraignment Assistance Benefit, Personal Injury/Negligence Benefit and Estate Probate and Administration Benefit which cover member, spouse and/or family members. See each benefit description for specific coverages.*

GENERAL RULES REGARDING COVERAGE

Enrollment

In order to receive benefits, you must complete a Levittown United Teacher Supplemental Benefits Fund Enrollment Card. The enrollment card provides necessary basic information: your name, address, social security number, birth date, marital status, etc. If you have not completed an enrollment card, it is essential that you do so at the earliest possible opportunity.

HOW TO USE THE LEGAL SERVICES PLAN

If you wish to make an appointment to consult a lawyer for benefits, call the Fund's panel law firm, Mirkin & Gordon, P.C., directly at 516-466-6030.

The initial appointment with the attorney will be made through the firm. Necessary forms and instructions for their use will be given to you by the attorney. You will be provided with an attorney from the panel law firm selected by the Fund. This firm will provide the covered member with the benefits of the legal services program. Your relationship with this law firm will be that of attorney and client. The attorney-client relationship will be exclusively between the covered member and the law firm. No member of the Fund, or any Trustee of the Fund can interfere in this relationship.

The legal services program is designed to help pay for covered legal services. The Fund cannot pay for all legal costs incurred, but it will help meet a substantial amount of such costs. You should explore, with an attorney of the panel law firm, the cost involved for any problem for which you seek help so that you and the law firm will have a working concept of what services are covered as well as what you will have to pay yourself. Remember, however, that it is not always possible to estimate total costs. When, after general consultation with the panel law firm, you decide to retain the panel law firm, you will then be requested to make initial appropriate payment as indicated in the plan of benefits.

As a covered member you are not compelled to use the plan provided by the Fund. You are free at all times to select an attorney of your own choosing and make payment to such an attorney for services, but the Fund will not absorb or be responsible for any part of the fees or charges of attorneys other than those representing law firms on the panel.

A covered member is also free at any time to discontinue the services of the panel law firm and, if he/she so desires, to secure the services of a non-panel attorney. However, in such an event the Fund will neither be responsible for nor absorb any part of the fees or charges of such other attorneys. In addition, the covered member continues to be obligated to the panel law firm for any cost already incurred above the scheduled amount.

The panel law firm may, under exceptional circumstances, at any time (as is customary in the case of the independent retention of private attorneys) not undertake, discontinue or withdraw from representation of any covered member with appropriate adjustment of fees. In such cases, the covered member is free to secure his/her own counsel; however, the Fund will neither absorb nor be responsible for any of the fees or charges of a non-panel attorney.

There is no subscription or registration fee to be paid by any covered member in active payroll status in order to entitle him/her to the benefits of the legal services program.

In instances where two covered members are involved in the same controversy or proceedings as adversaries, (and both members would have the right to the benefit under the rules of the Fund) each member will be provided access to an attorney or provided with a stipend by the Faculty Association Benefit Fund.

REPRESENTATION IN CIVIL MATTERS

The benefits of the Fund are divided into two major benefit categories: Representation in Civil Matters and General Legal Matters. All covered members are entitled to no more than one (1) Civil Matter, every two calendar years. Should you require representation in additional Civil Matters in a calendar year, you may submit a written request for consideration to the Fund's Board of Trustees, which must include information supporting your need. Upon consideration of your request, the Trustees will render a written decision within a reasonable period of time. The following section concerns itself with the specific benefits within this category.

LEGAL DEFENSE BENEFIT

Who is Eligible . . .Any covered member who is a defendant in a situation involving his/her rights in resisting a claim and has had a legal action started against him/her which does not fall within any of the specified benefits listed in this booklet*.

**Please note that special service benefits such as those involving divorce proceedings, separation proceedings, annulment proceedings and homeowner proceedings are covered by the schedules of fees contained under those specific headings in this booklet.*

As indicated above, you are entitled to representation in no more than one legal defense matter every two calendar years. Should you require representation in additional legal defense matters in a calendar year, you may submit a written request for consideration to the Fund's Board of Trustees, which must include information supporting your need. Upon consideration of your request, the Trustees will render a written decision within a reasonable period of time.

If a covered member issued jointly with another defendant, including a spouse/domestic partner, the matter will not be covered by the Fund unless special circumstances are presented to the Trustees and approved. You may submit a written request for consideration to the Fund's Board of Trustees outlining your special circumstances to which the Trustees will render a written decision within a reasonable period of time.

What is the Benefit . . . The Fund provides coverage through the panel law firm for all necessary legal services arising from the defense of a lawsuit or proceeding commenced against you in courts and administrative agencies. The following are only examples of some of the courts and agencies in which the Fund provides coverage under the Legal Defense Benefit:

Supreme, Surrogate's & District Courts of Westchester County; United States District Court for the Eastern and Southern Districts of New York; United States Customs Court; Supreme, Surrogate's and County Courts of Rockland, Putnam, Dutchess, New York, Brooklyn, Queens, Richmond, Bronx, Nassau and Suffolk Counties; Civil Courts of New York, Brooklyn, Queens, Richmond and Bronx Counties; District Courts of Nassau and Suffolk Counties; Administrative Agencies and Bureaus.

This benefit provides, for example, the legal defense cost of a lawsuit alleging breach of contract or against lawsuits involving garnishment or medical expense claims. A covered member's problem may be successfully resolved after consultation with a panel attorney or it may necessitate the steps leading to and including your defense in litigation or before an administrative agency.

The following schedule indicates the legal services available and the amount to be paid by the member at each stage:

Steps in the Legal Process Provided by The Fund through the Panel Law Firm	**Amount Paid by Fund Member**
A. Consultation	No Charge
B. Pre-Litigation: including, for example, negotiation of settlement including the drafting of any necessary papers	$15
C. Litigation: including, for example, third party complaint, Demand for Bill of Particulars, preparation of Jury Demand and court appearance, if necessary	$35

If the Legal Defense Benefit is concluded at the consultation stage, there is no cost to the member. However, if the Legal Defense Benefit is concluded at the pre-litigation stage, the cost to the member is $15; if the Legal Defense Benefit must enter the litigation stage, the cost to the member is an additional $35. Hence, the total cost to the member for a Legal Defense Benefit that reaches litigation is $50 ($15 + $35).

How to Obtain the Benefit . . . . To obtain this benefit, simply contact the panel law firm to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

The acceptance of representation in all cases will be conditioned upon a determination by the panel law firm that the defense of the case is not frivolous. Such a determination will be made by the panel law firm and reported to the Trustees for a final determination.

Exclusions

- The legal defense benefit will not cover any controversy, action, dispute, proceeding or matter, which involves a member's or their spouse's/domestic partner's business, commercial or investment interest.

- The legal defense benefit will not cover any controversy, action, dispute, proceeding or matter, which results from actions taken by a member or spouse/domestic partner acting on his/her own behalf as a general contractor for the construction of a new home or renovation of an existing home.

UNCONTESTED LEGAL SEPARATION BENEFIT

Who is eligible . . . Any covered member who desires to seek a separation from his/her spouse by means of a separation agreement mutually agreed upon by the parties or any relief through the court by instituting an action for an uncontested legal separation is covered by this benefit.

What is the Benefit? . . . There are two types of legal separation: uncontested and contested separation. The legal services program provides coverage for all circumstances in the legal process in uncontested separation proceedings.

Coverage is provided through the panel law firm for all necessary legal services which the preparation and negotiations of a separation agreement may require. The separation agreement may be prepared and executed with a minimum of consultation, or it may necessitate extensive negotiations with opposing counsel and spouse.

The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

A. Consultation	None
B. Uncontested or cooperatively agreed separation with minimal negotiation	$45.00
C. Separation agreement after extensive negotiation	$75.00

Where the parties do not wish to enter into a separation agreement, an uncontested action in court for a legal separation may be had.

The following schedule indicates the legal services available in an uncontested separation and the amount to be paid by the member in each circumstance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

A. Consultation	$0
B. Litigation: including, for example, conference, preparation of Summons and Verified Complaint, documents relating to maintenance and support of children (in proper instances, Findings of Fact and Conclusions of Law.	$180.00

How to obtain the Uncontested Legal Separation Benefit . . . To obtain the Uncontested Legal Separation Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

UNCONTESTED DIVORCE PROCEEDING BENEFIT

Who is Eligible . . . Any covered member is entitled to this benefit.

What is the Benefit . . . Divorce proceedings may be categorized as uncontested or contested. The Legal services program provides coverage for all steps of the legal process in uncontested divorce proceedings.

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

A. The member is entitled to ten hours of legal representation, at no cost to the member, in negotiating a divorce settlement until litigation must commence in instances where the panel attorney determines that litigation is necessary in order to maintain, defend, advance or assert the member's interest. (See "B" below) A divorce action will be initiated when:

1.	The member and spouse have agreed upon an uncontested divorce and no stipulation of settlement is required; or	$0
2.	The member and spouse had previously signed a separation agreement or stipulation of settlement and have agreed upon an uncontested divorce; or	$0
3.	The member requests representation in negotiating a stipulation of settlement (equitable distribution, child support, custody, visitation and maintenance, e.g.) and the spouse has retained an attorney. A stipulation of settlement is negotiated and executed, grounds are agreed upon and the spouse signs an affidavit agreeing upon the grounds for divorce.	$60

B. The member may (in addition to "A" above) retain the services of the panel law firm after the first ten hours of legal representation or once litigation is necessary to commence, subject to a written agreement of retention. The panel law firm has agreed to provide said representation with a 25% reduction in its hourly rate, which hourly rate has been established as $350.00 for calendar year 2014.

How to obtain the Uncontested Divorce Benefit . . . To obtain the Divorce Benefit, simply contact the panel law firm to request an appointment. At the time of appointment, you and the attorney from the panel law firm will complete the appropriate forms.

UNCONTESTED ANNULMENT BENEFIT

Who is Eligible . . . Any covered member is entitled to this benefit.

What is the Benefit . . . There are two types of annulment: uncontested and contested. The legal services program provides coverage for all steps in the legal process in an uncontested annulment proceeding.

The following schedule indicates the legal services available and the amount to be paid by the member in each circumstance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

Coverage includes, Summons, Complaint, Note of Issue, preparation of Findings of Fact, Conclusion of Law, Entry of Judgment and Finalization	$60.00

How to obtain the Uncontested Annulment Benefit . . . To obtain the Uncontested Annulment Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

ADOPTION BENEFIT

Who is Eligible . . . Any covered member who seeks representation in an adoption proceeding is covered by this benefit.

What is the Benefit . . . The Fund will provide you with an attorney from a panel law firm to represent you in formal adoption proceedings. This benefit does not include payment of any fees or expenses to adoption agencies or any other agencies, but is limited to those services normally rendered by an attorney to formalize an adoption. After all arrangements have been agreed upon, the panel attorney will prepare all petitions and allied papers and will appear in court with the parties in support of the adoption, if required.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

Consultation	$0
Preparation of Documents and Court Appearance for adoption of child	$65

How to Obtain the Benefit . . . To obtain the Adoption Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

PERSONAL BANKRUPTCY BENEFIT

Who is Covered . . . You are eligible if you are a covered member.

What is the Benefit . . . The Fund provides coverage through the panel law firm for all necessary conferences and legal services in the preparation of a petition to file for personal bankruptcy. Such a petition and schedules to file for personal bankruptcy may be finalized with a minimum of

consultation and negotiation or it may involve a number of exceedingly complex steps. In some situations, it may require attendance at meetings with creditors and settlement agreements.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH	AMOUNT PAID THE PANEL LAW FIRM BY MEMBER
Consultation	$0
Simple Personal Bankruptcy	$75
Complex Personal Bankruptcy	$100

How to Obtain the Benefit . . . To obtain the Personal Bankruptcy Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

CHANGE OF NAME BENEFIT

Who is Covered . . . You are eligible if you are a covered member.

What is the Benefit . . . This benefit provides legal advice and representation in the change of name procedure. Counsel will file all appropriate papers and represent you in the change of name process.

The following schedule indicates the legal services available and the amount to be paid by you at each stage:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH	AMOUNT PAID THE PANEL LAW FIRM BY MEMBER
Consultation	$0
Actual change of name procedure	$45

How to Obtain the Benefit . . . To obtain the Change of Name Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

HOMEOWNER RIGHTS BENEFIT

Who is Eligible. . . . Any covered member who owns a private dwelling, a condominium or cooperative apartment as a primary residence or is in the process of purchasing or selling such a primary residence or refinancing of a mortgage on a primary residence located within the geographic area covered by the Homeowners Rights Benefit.

The geographic area covered by the Homeowners Rights Benefit includes: Nassau, Suffolk, Westchester, Putnam, Rockland, Dutchess, Orange, New York, Brooklyn, Queens, Richmond and Bronx Counties in New York State. Real estate transactions outside of the plan's geographic limits that can be serviced by the panel law firm will be covered.

What is the Benefit . . . This benefit has two components:
(1) Legal advice or representation for the sale or purchase of any private dwelling, condominium or cooperative apartment in which the member primarily resides or plans to reside; or the purchase only of any unimproved property with the intention of constructing a home in which the member expects to primarily reside; or the refinancing of a mortgage on his or her primary residence. The legal services plan does not provide representation in any phase of the construction of the home, or in any controversy, dispute, proceeding or matter arising from the construction of any home, including one in which the member expects to primarily reside unless special circumstances are demonstrated and approved by the Trustees.

(2) Legal advice or representation in the defense of a mortgage foreclosure proceeding involving any of the above stated residences.

Regarding the first component of this benefit, the following schedule indicates the legal services available and the amount to be paid by the member in each instance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH	**AMOUNT PAID THE PANEL LAW FIRM BY MEMBER**
A. Consultation	$0
B. Negotiation, Advice and Representation in the sale, purchase, or refinancing of a primary residence.	$60

It should be noted that this benefit does not include any aspects of residential problems that involve Title searches or Title insurance nor the costs of same.

The second component of the Homeowner Rights Benefit is legal representation through the panel law firm attorney in defense of a proceeding to foreclose a mortgage on a dwelling which the member owns and in which the member primarily resides. A mortgage foreclosure problem may be resolved after consultation with a panel attorney or it may require the contesting of any action to foreclose the mortgage in the appropriate court.

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH	**AMOUNT PAID THE PANEL LAW FIRM BY MEMBER**
A. Consultation.	$0
B. Pre litigation: including for example, negotiation of settlement as well as the drafting of any necessary papers.	$15
C. Litigation: including, for example, Demand for Bill of Particulars, preparation of Jury Demand, Motions and court appearances.	$125

How to Obtain the Benefit …. To obtain the Homeowner's Rights Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

REPRESENTATION IN GENERAL LEGAL MATTERS

As indicated before, the benefits of the legal services program are divided into two categories: Representation in Civil Matters and General Legal Matters.

This section describes the General Legal Matters of the program. These benefits are provided by you in those instances where your legal problems do not fall within the benefits provided within the Representation in Civil Matters category.

The following section describes the benefits included within the General Legal Matters category.

GENERAL CONSULTATION BENEFIT . . . (Three Each Year)

Who is Covered . . . All covered members are entitled to this benefit.

What is the Benefit . . . This benefit provides you with an opportunity to consult with an attorney from the panel law firm concerning any legal questions whatsoever. This benefit is made available by the Fund at no charge to you.

The General Consultation Benefit does not include representation. If such representation involves a covered matter, the Fund will pay the cost of representation in accordance with its Benefit Schedule. Of course, if the matter is not covered, any further legal costs must be borne directly by you.

How to Obtain the Benefit . . . To obtain the General Consultation Benefit, simply contact the panel law firm to request a consultation appointment. At the time of the consultation, you and an attorney from the panel law firm will complete the appropriate forms.

DOCUMENT REVIEW BENEFIT*

Who is Covered . . . All covered members are entitled to this benefit.

**The document Review Benefit provides review and interpretation of documents only. The Document Review Benefit does not include representation. If such representation involves a covered matter, the Fund will pay the cost of representation in accordance with its Benefit Schedule. Of course, if the matter is not covered, then any further legal costs must be borne directly by the member.*

What is the Benefit . . . This benefit provides professional review and interpretation of all legal documents, such as: guarantees, warranties, installment purchase agreements, loans, leases, insurance policies and court papers by an attorney from the panel law firm. There is no frequency limitation placed upon the utilization of this benefit, which is provided at no cost to the member.

Exclusions and Limitations:

The following documents are not included in the Document Review Benefit:
A. Tax Returns
B. Work that is being prepared by other attorneys at the time of the Document Review Benefit.

How to Obtain the Benefit . . .To obtain the Document Review Benefit, simply contact the panel law firm to request a consultation appointment. At the time of the consultation, you and an attorney from the panel law firm will complete the appropriate forms.

WILL BENEFIT (once per year)

Who is Eligible . . . Any member and his/her spouse, if agreeable to the member, who wishes to execute a Will or have one reviewed or updated is covered by this benefit. In addition, the parent(s) and/or parent(s)-in-law of a member who wishes to execute a will, or have one reviewed or updated, is covered by this benefit.

What is the Benefit . . . The Fund provides coverage through the panel law firm for the preparation and execution of a Will with a simple children's trust for the member, his/her spouse (if agreeable to the member), the member's parent(s) and/or parent(s)-in-law under the supervision of an attorney without charge, not more than once in every consecutive year period.

The Fund makes this benefit available at no charge to the member, his/her spouse, parent(s) or parent(s)-in-law.

The geographic area covered by the Will Benefit includes: Nassau, Suffolk, Westchester, Putnam, Rockland, Dutchess, Orange, New York, Brooklyn, Queens, Richmond and Bronx Counties in New York State.

How to obtain the Will Benefit . . . To obtain the Will Benefit, simply contact the panel law firm to request an appointment. If both member and spouse desire a Will, it is recommended that they make the appointment together. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms. A second appointment will be necessary for the execution (signing) of the completed will(s).

LIVING WILL/HEALTH CARE PROXY BENEFIT/POWER OF ATTORNEY BENEFIT

Who is Eligible . . . You are eligible if you are a covered member or a covered member's spouse.

What is the Benefit . . . This benefit provides you and your spouse (if agreeable to the member), or domestic partner or a covered member's parent(s) and/or parent(s)-in-law, with the opportunity to have a living will/healthcare proxy prepared and executed under the supervision of an attorney from the panel law firm. This benefit is provided once every two calendar years at no cost to you.

A living will and/or health care proxy serves as a clear documented expression of an individual's carefully considered intention to have life-sustaining procedures withheld or withdrawn if he or she were to suffer from a catastrophic illness, disease or injury from which there is little likelihood that he or she would recover to enjoy a meaningful quality of life.

A power of attorney appoints an individual of your choosing to conduct your affairs immediately or upon the happening of a catastrophic event, which results in your incapacity.

How to Obtain the Benefit . . . To obtain the Living Will/Health Care Proxy/Power of Attorney Benefit, either you or your spouse should contact the panel law firm to request an appointment. If both husband and wife/domestic partners desire a living will and/or health care proxy, it is recommended that you make an appointment together. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

PLANNING FOR ELDERLY BENEFIT

Who is Eligible... you are eligible if you are a covered member, a covered member's spouse, a covered member's parent(s) or a covered member's parent(s)-in-law.

What is the Benefit…This benefit provides you, your spouse, your parent(s) and/or your parent(s)-in-law with an opportunity to consult with an attorney from the panel law firm on matters involving the placement of elderly in nursing homes, available Medicare entitlements and health planning for the elderly. This benefit includes the preparation of powers of attorney and is offered at no cost to you.

The Fund makes this benefit available at no charge to the member, his/her spouse, parent(s) and/or parent(s)-in-law.

How Is the Planning for the Elderly Benefit Obtained…To obtain the Planning for the Elderly Benefit, either you or your spouse/domestic partner should contact the panel law firm to request an appointment. At the time of the appointment, an attorney from the panel law firm will complete the appropriate forms with the client.

ESTATES AND ADMINISTRATION BENEFIT

Who is Eligible . . . You are eligible if you are a covered member or a covered member's eligible dependent who is named as Executor in a Will. You are also eligible if you are named as executor in a will by a covered member. If there is no Will, you or an eligible dependent who would qualify under the intestacy laws to serve as Administrator of the estate will be eligible.

What is the Benefit . . . This benefit provides all legal services which may be required in connection with the handling of an estate from its inception (the probate of a Will or Petition for Letters of Administration where there is no Will), through all phases of estate administration including tax proceedings and "winding up" of the estate (through accounting and distribution).

With respect to the estate of a deceased member, these services are provided to the surviving spouse or domestic partner or eligible dependent children in those instances where the spouse or domestic partner or eligible dependent children would be entitled to be appointed Executor or Administrator.

PLEASE NOTE: This benefit does not provide legal services of an adversarial nature, e.g., to contest an existing Will.

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

Consultation: $0

The panel law firm has agreed to provide legal representation in these matters with a 25% reduction in its hourly rate, which, for 2017 is $450.00. (This is $337.50 per hour for 2017.)

The retainer for these legal services is between the estate representative and the law firm. It should be discussed and executed at the initial appointment.

PLEASE NOTE: This benefit DOES NOT provide legal services of an adversarial nature, e.g., to contest an existing Will.

How is the Probate and Estate Administration Benefit Obtained . . . To obtain the Probate and Estate Administration Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

PERSONAL INJURY (NEGLIGENCE) BENEFIT

Who is Eligible . . . A member and/or all members of his/her immediate family who has suffered a personal injury as a result of negligence is covered by this benefit.

What is the Benefit . . . The Fund provides coverage through the panel law firm for all legal services, through trial if necessary, in connection with the prosecution of a claim for personal injury as a consequence of negligence in cases which legal counsel believes are worthy of prosecution.

The member will be represented on the basis of a contingent fee of 33 1/3% of the net sum recovered.

What does "Contingent Fee" Mean . . . It means that the fee is contingent upon successful recovery, whether by suit, settlement or otherwise. Thus, if there is no recovery, there is no fee. Conversely, the more that is recovered, the greater the fee. . . all dependent upon a successful conclusion of the matter.

As customary, whether the litigation is successful or not, you are required to reimburse the firm for all disbursements, charges and other expenses, such as: medical and police reports, investigations, witness fees, etc. Also, as is customary, in computing this contingent fee, liens in favor of hospitals, doctors, etc. or other statutory liens upon recovery, are not to be deducted. Such amounts would be paid out of the injured party's share of the recovery.

How is the Personal Injury (Negligence) Benefit Obtained . . . To obtain the benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

ARRAIGNMENT ASSISTANCE – TELEPHONE CONSULTATION BENEFIT

Who is Eligible . . . You are eligible if you are a covered member or dependent who is a defendant in a criminal proceeding in Nassau, Suffolk, Westchester, Putnam, Dutchess, Rockland or Orange Counties, or the boroughs of New York City.

What is the Benefit . . . This benefit provides coverage through the panel law firm for necessary legal services arising from an arrest which may lead to immediate imprisonment.

This benefit provides, for example, the legal defense cost of telephone assistance by an attorney where you or your dependent is charged as the defendant in a criminal matter. The Fund has arranged for this benefit to be provided on an emergency 24-hour basis. A Hotline telephone number will be available for 24-hour coverage. It is important to note, however, that this benefit does not cover the costs of legal assistance beyond the arraignment telephone consultation stage. If you or your dependent is interested in obtaining legal services beyond this consultation stage, you must make the necessary arrangements directly with the panel law firm or retain another attorney of your choice.

The following schedule indicates the legal services available and the amount to be paid by the member:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH
AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

Consultation $0

How to Obtain the Benefit . . . To obtain the Arraignment Assistance Benefit, contact the panel law firm. This service is available at any hour of the day or night by calling (516) 466-6030

CONSUMER PROTECTION BENEFIT

Who is Eligible . . . Any covered member is entitled to this benefit.

What is the Benefit . . . This benefit provides you with coverage through the panel law firm for a broad range of legal services which might be needed to institute and pursue action against fraudulent practices by merchants, department stores, home repair contractors, public utilities, automobile dealers, appliance dealers, etc. Utilization of this benefit is limited to two matters per member per calendar year and the matter must involve a purchase costing $500 or more.

The following schedule indicates the legal services available and the amount to be paid by you in each circumstance:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH	**AMOUNT PAID THE PANEL LAW FIRM BY MEMBER**
Consultation	$0
Representation by Written Communication	$0
Litigation in Small Claims Court	$50
Litigation in Courts other than Small Claims Court Small Claims Court	$100*
Representation with Appropriate Federal Agencies (e.g. F.T.C., etc.)	$100*

**If a lawsuit involves a consumer purchase of $5,000 or more - e.g., "lemon" car - then the cost to you for litigation or representation will be $250.*

Some legal services that are not provided under this benefit include, but are not limited to, suits for punitive damages, class actions and commercial enterprises.

How to Obtain the Benefit . . . To obtain the Consumer Protection Benefit, simply contact the panel law firm to request an appointment. At the time of the appointment, you and your attorney from the panel law firm will complete the appropriate forms.

IDENTITY THEFT PROTECTION BENEFIT

Who is eligible . . . Any member who wishes legal consultation in connection with an identity or personal information theft issue is covered by this benefit.

What is the benefit . . . The Fund provides coverage through the panel law firm for a member to consult with an attorney if the member believes he/she has been the victim of an act of identity or personal information theft including but not limited to the following examples:

- using or opening of a credit card account in the member's name, fraudulently;
- opening telecommunications or utility accounts in the member's name, fraudulently;
- passing bad checks or opening a new bank account in the member's name, without authorization; and
- obtaining a loan in the member's name, fraudulently.

The panel law firm will provide consultation and assistance* to a member in connection with their contacting and reporting an act of identity theft to the three major credit bureaus, the security departments of the appropriate creditors or financial institutions, the police and the Federal Trade Commission.

The Fund makes this benefit available at no charge to member.

How is the Identity Theft Benefit Obtained . . . To obtain the Identity Theft Benefit, simply contact the panel law firm to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

**The Identity Theft Benefit does not include representation in litigation other than that already provided in the Consumer Protection Benefit.*

ESTATE PLANNING/TRUSTS BENEFIT

Who is Eligible…You are eligible if you are a covered member, a covered member's spouse or domestic partner (if agreeable to the member) or a covered member's parent(s) and/or parent(s)-in-law.

What is the Benefit…The benefit provides covered members and their spouses/domestic partners, parent(s) and/or parent(s)-in-law with the opportunity to have estate planning trusts prepared and executed under the supervision of an attorney from the panel law firm.

The following schedule indicates the legal services available and the amount to be paid by the member:

STEPS IN THE LEGAL PROCESS PROVIDED BY THE FUND THROUGH AMOUNT PAID THE PANEL LAW FIRM BY MEMBER

A. Consultation.....$150.00 *

B. Preparation and execution of certain estate planning trusts, as follows:

- **Irrevocable Life Insurance Trust ("ILIT") -** Designed to remove life insurance proceeds from the insured's and the surviving spouse's taxable estate.
- **Revocable Grantor Trust (Living Trust) -** Created during a person's lifetime and can be amended or revoked by the grantor at any time.
- **Supplemental Needs Trust (Escher Type Trust) -** Allows a person receiving governmental assistance (Medicaid) to receive prescribed amounts of income and principal from trust without jeopardizing governmental assistance.
- **Marital Trust** – A trust, which if containing specific statutory provisions will qualify for the marital deduction, and therefore not be included in the decedent's taxable estate.
- **Qualified Personal Residence Trust ("QPRT") -** Allows a person to place his or her personal residence in a trust and continue to have full use of the trust for a number of years, providing such term is less than the grantor's life expectancy.

20% Off The Usual and Customary Fee**

* *To be credited to fee for preparation of trust.*

** Usual and customary fee charged by the panel law firm is $2,500 per trust for all trusts except QRPT trusts, which is $3,000 per special trust. Fees may change year to year. All fees for these trusts include the preparation of one deed to transfer New York State real estate (where applicable) to the trust. It may be required, in some instances, to prepare new Wills to coordinate with the specially tailored estate plan. The fee for said Will will vary, depending upon the nature of the estate plan.

How to Obtain the Benefit…To obtain the Estate Planning Benefit, you should contact the panel law firm to request an appointment.

COUNSELING OF UNEMANCIPATED* CHILDREN BENEFIT

Who is eligible . . . Upon application of the member/parent, your unemancipated child, who is over 18 years of age and qualifies as an eligible dependent child (as defined by the rules of the Fund).

What is the benefit . . . The Fund provides coverage through the panel law firm for consultation and document review services to your unemancipated child on matters involving the following:

- Legal responsibilities that affect your child when they turn age 18, whether or not they are emancipated;
- Contract review;
- Lease review and real estate issues;
- Agreements and documents associated with educational institutions (i.e. universities and colleges);
- Loan agreements and other credit matters; and
- Identity theft matters.

How is the Counseling of Unemancipated Children Benefit obtained . . . To obtain the Counseling of Unemancipated Children Benefit, simply contact the panel law firm to request an appointment for your child. At the time of the appointment, your child and an attorney from the panel firm will complete the appropriate forms.

Exclusions . . . Excluded from the Counseling of Unemancipated Children Benefit is advice or consultation in any controversy, dispute or proceeding with the covered member/parent.

**An unemancipated child is any dependent child (as defined by the rules of the Fund) who is over 18 years of age and fully dependent on you/the member for support.*

APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS BENEFIT

Who is eligible …Any covered member, covered member's spouse, covered member's parent(s) and/or parent(s)-in-law.

What is the benefit…This benefit provides you, your spouse , your parent(s), and/or parent(s)-in-law with the opportunity to have an Appointment of Agent to Control Disposition of Remains document prepared and executed under the supervision of an attorney from the panel law firm.

An Appointment of Agent to Control Disposition of Remains serves as a clear documented designation of a burial agent and expression of special directions of how the individual's burial is to be accomplished.

The Fund makes this benefit available at no charge to member.

How is the benefit Obtained…To obtain the Appointment of Agent to Control Disposition of Remains benefit, simply contact the panel law firm to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

DESIGNATION OF PERSON IN PARENTAL RELATION BENEFIT

Who is Eligible…You are eligible if you are a covered member.

What is the Benefit…This benefit provides the covered member with the opportunity to have a Designation of Person in Parental Relation ("Designation") prepared and executed under the supervision of an attorney from the panel law firm.

A Designation designates another person (the "Designee") as a person in parental relation to a minor or incapacitated person to act on his\her\their behalf in matters relating to education and health care. The Designation is a very useful document for parents who must leave their child with a caregiver for a limited period of time. If drafted properly, the Designation will be valid for up to 6 months.

NOTE: With respect to a covered member who wishes to be named Designee, an attorney from the panel law firm will provide a special consultation to confirm that a Designation one may receive is in conformity with the law.

How to Obtain the Benefit…To obtain the Designation of Person in Parental Relation Benefit, you should contact the panel law firm to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

GENERAL EXCLUSIONS FROM ALL LEGAL SERVICES BENEFITS OF THE FUND

All legal services provided by the Fund have been specifically stated and described. Any legal service that has not been so described can be considered excluded from the Fund Plan of Benefits. However, to guide you in your use of the Fund benefit package, this section lists specifically, but without limitation, particular exclusions from the Plan:

- Any controversy, dispute or proceeding with or against the employer or the employer's agents or officers;

- Any controversy, dispute or proceeding directed against the Union or any of its affiliated bodies, e.g., the Fund, or any of the officers, agents or attorneys of the Union and its affiliated bodies;

- Any controversy, dispute or proceeding in which the Fund would be prohibited from defraying the cost of legal services by any provisions of the law;

- Any controversy, action or proceedings in which representation on a contingent fee basis is normally and customarily available or where the fee is payable by virtue of statute or by order of court;

- Class actions or interventions or amicus curiae activities. Two or more parties may not pool or combine their benefits for the purpose of asserting a claim in which they have a mutual interest;

- Any matter concerning the preparation of filing of income tax returns, or the payment of income taxes;

- Any controversy, action, proceeding or dispute in which the legal services are available through insurance or through any government agency or attorney (Federal, State or local);

- Any controversy, dispute or proceeding in which you were previously represented by a lawyer;

- Any controversy, dispute, proceeding or matter which involves a member's business, commercial or investment interest;

- Any legal expenses incurred for a matter which commenced before you became eligible to receive a benefit under the Plan;

- Any controversy, dispute, proceeding or matter that cannot be litigated or otherwise handled within Nassau, Suffolk, Westchester, Putnam, Rockland and Dutchess Counties, and New York City in those tribunals described in the Legal Defense Benefit section;

- Fund will not pay claims for services or advice when such activity involves a duplication of the same service or advice previously obtained in connection with the same problem and previously claimed for under the Plan.

The Fund will not pay court costs and/or filing fees, nor in any event will the Fund pay fines, penalties or any amounts in which a member or member's eligible dependent may be cast in judgment.

If you have any questions about coverage, benefits or exclusions, please contact the fund.

HEARING AID BENEFIT

Who is eligible

- Covered members
- Eligible enrolled dependents of covered members

What are the terms and conditions of this benefit

- $2,000 reimbursement of hearing aid expenses per covered person as a supplement to benefits provided by general health plans.
- The benefit is payable per eligible person, NOT per ear.
- Payable for hearing aids received on or after March 1, 2022.
- Reimbursement is limited to the cost of the hearing aid device only. Other costs, including, but not limited to, hearing exams, hearing aid fitting, repairs and batteries are not covered by this benefit.
- Reimbursement will be allowed as follows:
    - Once every four (4) years (48 months) for enrollees over twelve (12).
    - Once every twenty-four (24) months for enrollees twelve (12) and under but only if existing hearing aid can no longer compensate for the child's hearing loss.