FACULTY ASSOCIATION OF
SUFFOLK COMMUNITY COLLEGE
BENEFIT FUND

Suffolk Community College
533 College Road
Selden, New York 11784-2899
(631) 732-6500 or (631) 451-4323
www.fascc.org

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Daniel H. Cook Associates, Inc.
253 West 35th Street - 12th Floor
New York, NY 10001
1 (212) 505-5050

Counsel

Mirkin & Gordon, P.C.

Accountants

Buchbinder, Tunick & Company

January 2016

Dear Faculty Association Benefit Fund Member:

As you know, since publication of the last booklet in February 2007, the Trustees of the Faculty Association Benefit Fund have made significant changes to the Fund's benefit plan. This revised benefits booklet describes all the benefits currently available to you and the procedures to access those benefits through the Faculty Association of Suffolk Community College Benefit Fund.

One of the new features of this revised benefits binder is that the binder will allow for pages to be removed and added if there is a particular benefit change. Therefore, it is important that you retain this benefits binder in an accessible, safe place. In addition, the dental schedule of benefits will now be included in the binder. Because the Trustees review the dental benefits of the Fund yearly to make sure that the schedule is current with benefits offered by other similar funds and competitive enough to attract and keep participating dentists as part of our plan, the Trustees want members to have the most recent schedule available in print when they need it. Of course up-to-date information about your benefits is always available at www.fascc.org. Just click the Benefit Fund button.

The following briefly describes the changes since the booklet was last published:

• **Dental Benefits:** Effective September 1, 2015, reimbursement levels for many dental procedures, including the more costly procedures, have been increased. As a result, many of these procedures will now be reimbursed at 60% of the average fee being charged by dentists utilized by our members. Remember, if you use a dentist on our panel, you will have no out-of-pocket costs for covered services.

• **Optical Benefits:** Also effective September 1, 2015, GVS has a new concierge service. You now have access to the GVS website, www.generalvision.com, where you can check your eligibility, view your plan, view your frame selection and schedule an appointment. A list of GVS services and service providers are included in this booklet.

• **Legal Services Benefits:** An identity theft protection benefit has been added.

Obviously, the changes cited above only highlight the basic elements of the actual changes in the Fund benefits. We suggest that you read this booklet carefully and share it with your eligible family members. If you have any questions, please contact the Fund office at 631-732-6500.

IN THE NAME OF THE TRUSTEES:

Tom Breeden	Joyce Gabriele	Dante Morelli
Cynthia Eaton	Marie Hanna	Sean Tvelia

In solidarity and trust,
Kevin Peterman, Chairperson

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BENEFITS

HIGHLIGHTS OF YOUR BENEFITS

This section of your booklet provides the highlights of benefits provided by the Faculty Association of Suffolk Community College Benefit Fund ("FA Benefit Fund"). All of the benefits are described in detail in the appropriate sections later in the booklet.

ACTIVE MEMBER AND DEPENDENT COVERAGE

DENTAL

Participating Provider Option: No out-of-pocket expenses for covered benefits; participating providers are reimbursed directly from the FA Benefit Fund. Call the Fund office 631-732-6500 to confirm that your current provider continues to participate on the FA Benefit Fund's panel of participating providers or to receive a list of participating dental providers in your area.

Dental Schedule of Allowance: Maximum coverage of $2,750/covered person/plan year (Sept. 1 - Aug. 31); periodontal maximum of $2,000/covered person/plan year; lifetime implant allowance of $3,500; and lifetime orthodontia allowance of $5,991/covered person.
Note: All plan maximums are based on the Fund's Schedule of Dental Allowances in effect at the time services are rendered.

Submit a claim form (obtained from the FA Benefit Fund Office or the union's website www.fascc.org) and be reimbursed up to the scheduled amount. If you use a participating dentist, no claims forms need to be filed.

OPTICAL

The Fund provides optical coverage for eligible FA Benefit Fund members once each plan year (Sept. 1 - Aug. 31). In brief, the benefit provides the following:

Participating Provider Option: No out-of-pocket expenses for a comprehensive eye exam, selected frames and lenses from more than 75 vision care panel doctors and optical centers in the Long Island and metropolitan New York City area. This option establishes maximum copayments for premier/metal frames and additional services beyond the basic benefit. Payment will be made by you directly to the participating provider. Call the Fund office or visit our website at www.fascc.org for a list of providers.

Out-of-Network Option: Payment will be made to you for actual expenses not to exceed $10 for an exam and up to $35 for covered materials (frames, lenses, contacts). Call the Fund office for a Reimbursement Claim Form.

PRESCRIPTION DRUG COPAYMENT REIMBURSEMENT

Effective with prescriptions filled in 2014, copayment reimbursement is up to a maximum of $500/family/per calendar year plus an additional one percent of each eligible copayment submitted in excess of $500. Download the claim form from our website www.fascc.org or call the FA Benefit Fund office at 631-732-6500 for a claim form and submit it along with a pharmacy print-out or your prescription drug carrier's printout showing the copayment amounts. Reimbursement may be claimed only once in a calendar year.

HEARING AID

Reimbursement of up to $1,500 once every rolling 36 months toward the purchase of a hearing aid. Download the claim form from our website, www.fascc.org, or call FA Benefit Fund office 631-732-6500 for a claim form and submit along with the bill.

DEPENDENT CARE BENEFIT

Reimbursement of up to $1,500 once every rolling 36 months toward the purchase of a hearing aid. Download the claim form from our website, www.fascc.org, or call the FA Benefit Fund office at 631-732-6500 for a claim form and submit along with the bill.

LIFE INSURANCE

$10,000 life insurance benefit payable to the member's designated beneficiary upon the death of the member. A notarized designation of beneficiary form must be on file. (Forms available at FA Benefit Fund office.) Anyone needing information on filing a claim should call the FA Benefit Fund office at 631-732-6500.

BURIAL BENEFIT

$1,000 to help defray the cost of funeral expenses upon the death of either the member or the member's spouse or domestic partner. Single persons must file a designation of beneficiary form (obtained from the FA Benefit Fund office). Submit a death certificate, along with the member's Social Security number, to claim benefits.

General Information

GENERAL INFORMATION

FUND INFORMATION

The Faculty Association of Suffolk Community College Benefit Fund ("FA Benefit Fund") is a legal entity separate and distinct from the Faculty Association of Suffolk Community College ("Faculty Association") and was established as a result of collective bargaining between the County of Suffolk and the Faculty Association. The FA Benefit Fund provides supplemental health-related and other benefits to its members and eligible dependents. Contributions to the FA Benefit Fund are predicated on the amount stipulated in the collective bargaining agreement and other pertinent documents.

The primary source of contributions to the FA Benefit Fund is the employer, Suffolk County Community College. Contributions are provided at an annual rate, prorated bi-monthly, on behalf of each covered active employee. In accordance with the Agreement and Declaration of Trust, the contributions are used to provide benefits for the covered members and their eligible dependents and to finance the cost of administration.

The FA Benefit Fund is governed by a Board of Trustees comprised of seven members, six of whom are designated by the Faculty Association and one (1) of whom is designated by the Guild of Administrative Officers, according to the Agreement and Declaration of Trust. The current members of the Board of Trustees are listed at the beginning of this booklet.

The Board of Trustees employs personnel who are responsible for the daily functioning and operation of the Fund and a Third Party Administrator whose primary function is the processing of claims.

ENROLLMENT

In order to receive benefits you must complete an FA Benefit Fund Enrollment Card. This card may be obtained from the Fund office. Once you become enrolled, it is important that you notify the Fund office, in writing, of any changes in your marital or family status and any change of your address. Payment of benefits can be put in jeopardy if the member fails to notify the Fund of subsequent changes in marital status or change of dependent status or domicile or neglects to confirm college-attendance status of a dependent child of their household. Proof of a change in marital status must be provided by sending a copy of your divorce decree/judgment, signed by a judge, to the Fund office. Once the Fund receives the decree/judgment, you must complete a new enrollment card and designation of beneficiary form for the Fund's burial benefit and life insurance benefit and any other benefits which may become payable upon your death. The provision of the divorce decree/judgment will not effect the designation of your former spouse on the beneficiary card for these benefits, irrespective of what the judge has ordered

or the parties have agreed to. You must complete, sign and file with the Fund office a new enrollment card in order to change your beneficiary designation. Only those beneficiaries listed on a member's duly executed designation of beneficiary card will be entitled to receive the appropriate benefits.

CLAIMS FILING

All claims for benefits must be submitted on claim forms made available by the Fund office or the Third Party Administrator. Claims must be accompanied by any information or proof requested and reasonably required to process claims including your name, address and Social Security number.

With respect to any benefits payable to a deceased member upon their 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, 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 surviving parent(s), equally or
d. if no surviving parent(s), to the surviving sibling(s), equally; or
e. if no surviving sibling(s), to the covered member's estate.

RIGHT TO APPEAL

The benefits provided by the FA Benefit Fund may be changed by the Benefit Fund's Board of Trustees. The Fund's Trustees adopt rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust Indenture which established and governs the FA Benefit Fund operations.

Decisions of the Fund Administrator and Fund Third Party Administrators (jointly considered the "Fund Office") are subject to review by the Trustees upon appeal. The Fund Office uniformly applies all rules. The action of the Fund Office is subject only to review by the Fund's Trustees. An appeal must be filed with the Fund within sixty (60) days of denial of the claim, by submitting notice in writing to the Benefit Fund's Board of Trustees, Faculty Association of Suffolk Community College Benefit Fund, Southampton 224D, 533 College Road, Selden, New York 11784. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final, conclusive, and binding on all persons.

Eligibility

ELIGIBILITY

COVERED MEMBER

In order to be eligible for benefits through the FA Benefit Fund, you must be a covered member. Covered members include Unit III employees of Suffolk Community College covered by the collective bargaining agreement between the Faculty Association and the County of Suffolk and on whose behalf contributions are required to be made; officers and employees of the Faculty Association and the Fund on whose behalf the Faculty Association or the FA Benefit Fund makes contributions; such retirees whom the Trustees may determine are eligible to participate in this Fund; and other employees of the County of Suffolk in other bargaining units and non-bargaining units whom the Trustees may determine are eligible to participate in the FA Benefit Fund. You are entitled to benefits as long as you are in active payroll status or are an eligible retiree. Active payroll status means the period for which contributions are required to be made on your behalf by the employer. Covered members who are on unpaid leaves of absence remain eligible for benefits for so long as they are on approved leave, provided they make the required contribution to the FA Benefit Fund. (See section entitled COBRA for further details.) In addition, adjunct faculty are eligible for the Legal Services Program designed for those members.

Employees covered by the FA Benefit Fund will be eligible for benefits on the first day of employment. All benefits terminate at the end of the month in which the last contribution has been received by the Fund on the employee's behalf.

ELIGIBLE DEPENDENTS

Your eligible dependents are covered for certain benefits as outlined in this booklet. Eligible dependents include:

- Your spouse
- Your domestic partner
  - who is eighteen years of age or older;
  - who is not married or related by blood in a manner that would bar marriage in New York State;
  - who has an exclusive mutual, close and committed personal relationship with the member;
  - who lives with the member and has been living with same on a continuous basis for six months* and you are able to provide proof of residency and financial interdependence**; and
  - has not terminated the partnership.

*residency requirements reduced to six (6) months effective January 1, 2010

**evidence of financial interdependence is not required if the member has received, and provides the Fund office with a copy of, a certificate of domestic partnership issued by the Employee Benefits Unit for the Employee Medical Health Plan of Suffolk County ('EMHP").

A person may be enrolled as a domestic partner if his/her partner is a Unit III or Unit IV employee of Suffolk Community College on the date of registration for whom the Employer makes contributions to the FA Benefit Fund or has retired as a Unit III or Unit IV employee of Suffolk Community College and is currently a member of the FA Benefit Fund. No person is eligible to be enrolled as a domestic partner who at the time of enrollment or at any time during the prior six months was enrolled as a member of another domestic partnership or was married to another individual and whose divorce decree was issued less than six months prior to submission of the application for enrollment.

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health-related benefits is treated as income to the covered member/employee for tax purposes when a person who is not a qualified dependent under Federal IRS rules is covered under the Fund. Please ask your tax consultant how enrolling your domestic partner will affect your taxes.

If the partnership ends, the member must notify the Fund office and end coverage for their domestic partner. There will be a one-year waiting period from the termination date of a previous partner's coverage before the member may again enroll a domestic partner.

Members who fraudulently enroll a domestic partner are held financially and legally responsible for any benefits paid.

Eligible dependents (continued):

- Your unmarried dependent children who have not reached their 19th birthday (including legally adopted children) or stepchildren who reside with the covered member and for whom the covered member provides full financial support and who have not reached their 19th birthday. To establish eligibility of a member's step-child, the member must submit an affidavit verifying that the 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.

  Other children who reside permanently with you in your household, who are chiefly dependent on you for support, are also eligible. To establish the eligibility of such a child, the member must submit an affidavit verifying that the child resides full time with the member and proof of both residency and financial dependence, as shown by income tax returns or a court order of guardianship for the child. The affidavit is available from 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. A Student Verification Form (obtained from the Fund office) must be completed and submitted to the Fund before a claim can be honored. This form must be filed each semester.

  Part-Time Students Completing Graduation Requirements

  Your unmarried dependent children who are over age nineteen (19) but under age twenty-five (25) who need less than a full-time course load to satisfy requirements for graduation may also be eligible. They must:

  - Otherwise qualify as an eligible dependent of the enrollee;
  - Have been a full-time student in the term immediately preceding the semester or trimester in which course requirements will be completed; and
  - Provide the Benefit Fund office with a statement from their school or college administrator which verifies the student's status.

- Your unmarried children, regardless of age, who are incapable of self-sustaining employment by reason of mental or physical handicap and who become so prior to their attainment of 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 office within 31 days after the date he or she attains 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 office from time to time at its request.

COORDINATION OF BENEFITS

You may be entitled to receive benefits under our benefit plan and another group benefit plan, if your spouse or domestic partner also has benefit coverage. In this case, the two plans will coordinate their benefit payments so that the combined payments of both plans will not be more than your actual expenses. The primary coverage plan will pay its full benefits. Then the secondary coverage plan will pay any expenses that are not completely covered by the primary coverage plan's benefits. No plan pays more than it would without the coordination of benefits provision.

Claim Procedures under the Coordination of Benefits Provision

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

- (a) Submit your claim to the Fund office.
- (b) After you have received payment for such claim from the Fund, you may submit this claim to the other group plan under which you are eligible for benefits.
- (c) You will receive any additional benefits, which may be due for this claim under the second plan, but the total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of allowable expenses.

[2] If your spouse or domestic partner has a claim and is eligible for benefits under another group plan:

- (a) He/she must submit the claim to his/her plan first.
- (b) After this claim is paid by that plan, it may be submitted to this Fund accompanied by an explanation of benefits received from the other plan.
- (c) Any additional benefits which may be due for this claim will be paid by this Fund, but the total amount paid for this claim from this plan will not exceed 100% of allowable expenses as determined by the Fund.

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

- (a) Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in a calendar year.
- (b) After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan.

(c) The payment you receive for each claim from both plans cannot exceed 100% of allowable expenses.

[4] If the claim is submitted for a child whose parents are divorced when one parent is a covered member of this Fund and the other parent is a covered member of another plan:

(a) If the parent with custody has not remarried,

(i) submit the claim to the plan which covers the parent with custody first.

(ii) after the claim has been paid by the first plan then it may be submitted to the second plan along with an explanation of benefits received from the first plan.

(b) If the parent with custody has remarried,

(i) submit the claim to the plan which covers the parent with custody first.

(ii) submit the claim to the plan which covers the stepparent second.

(iii) submit the claim to the plan which covers the parent without custody last.

(c) In the event there is a court order which establishes financial responsibility for the medical, dental or other health care expenses of the child, submit the claim to the plan which covers the parent with the court-ordered responsibility first.

OVERPAYMENT/FUTURE OFFSET

In the event you receive an overpayment of Benefit Fund benefits, on your behalf or on behalf of your dependent, you are obligated to refund said overpayment to the Fund immediately. In the event you fail to refund said overpayment, the Fund can offset said overpayment against future benefits until said overpayment is fully recouped or suspend your benefits until said overpayment is paid in full. Such offset and/or suspension can be applied to the member's and eligible dependents' benefits.

AMENDMENT OR TERMINATION OF BENEFITS

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

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

When the Fund is terminated;

When you are no longer eligible;

When there is a non-payment of the direct pay premiums; or

When the College ceases to make contributions on your behalf to the Fund.

Your dependent's coverage will also terminate when he or she is no longer your eligible dependent.

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

How to Decline Dental and Optical Coverage

Actively employed members may decline coverage of Fund benefits (dental and optical) for themselves and/or any enrolled dependents at any time by completing a Declination of Coverage form, which can be obtained by contacting the Fund office.

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

A federal law, HIPAA, requires the Benefit Fund to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which was distributed to call current members of the Fund prior to April 14, 2004, and is distributed to all new members upon enrollment, a copy of which is available from the Fund Administrator.

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 HIPAA's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

Under HIPAA, you have certain rights with respect to your protected heath information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Fund or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

EXTENSION OF BENEFITS TO DEPENDENTS

If a covered member dies, those benefits otherwise available through COBRA will be extended to the spouse or domestic partner and eligible dependent children of the member, at no charge for a period of 90 days after the death (extended benefits period). An extension of the legal general consultation benefit for which the deceased was eligible is also granted to the surviving spouse or domestic partner for 90 days. If there is no surviving spouse or domestic partner, then the legal general consultation benefit is granted to your eldest surviving dependent.

CONTINUATION OF COVERAGE (SELF-PAY) AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA).

Federal law requires that most group health plans (including the Faculty Association of Suffolk Community College Benefit Fund, the "Fund") give employees (known as "members" in the case of the Fund) and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan (in this case, the Fund's plan of benefits under which the individual was covered). Depending on the type of qualifying event, "qualified beneficiaries" can include the employee/member (or retired employee/member) covered under the Fund's plan, the covered employee's/member's spouse/domestic partner, and the dependent children of the covered employee/member.

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

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 College, 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 College, 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 Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

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 Administrator with a copy of an SSA disability determination letter within 60 days of the determination in order to extend the period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Fund Administrator 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 Administrator 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 submit it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the member's/employee's spouse may elect continuation coverage even if the member/employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The member/employee or the member's/employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your Fund health-related benefits coverage may affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Fund's health-related benefits coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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's Administrator at 533 College Road, Southampton 224D, Selden, New York 11784 or by calling 631-732-6500 or 631-451-4323.

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 your and your family's rights, you should keep the Fund informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

COVERAGE FOR DEPENDENT SURVIVORS

A. Active Members

Coverage After the Extended Benefits Period Ends:

Your enrolled spouse who has not remarried, or domestic partner who has not married or entered into another domestic partnership, and eligible enrolled dependent children will be allowed to continue those benefits otherwise available through COBRA on a self-pay basis under the Fund after the extended benefits period ends, for as long as the appropriate self-pay premium is remitted. This is available to your eligible dependents only if you completed at least 10 years of service.

Notification: An enrolled dependent survivor who wishes to continue coverage under the Fund must make application and the required payment for the coverage within 90 days of the death of the employee. Applications made after this period of time may be denied. For information on the cost or duration of dependent survivor coverage, contact the Benefit Fund Administrator.

Coverage For Your Enrolled Dependents If Your Spouse or Domestic Partner Loses Eligibility or Dies:

If your enrolled surviving spouse remarries or dies or your domestic partner enters another domestic partner relationship, marries or dies, your eligible enrolled dependent children may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents. If they no longer meet these requirements, they may continue coverage through COBRA (see COBRA section). If your survivor is eligible for dependent survivor coverage but chooses not to participate or fails to make the required payments, coverage will be terminated permanently. Your survivor may not re-enroll.

If Your Family is Not Eligible for Dependent Survivor Coverage:

If your enrolled spouse and dependents are not eligible for survivor coverage under the Fund, they may continue their coverage for a limited time under COBRA (see COBRA section).

B. Retirees

Upon the death of a retiree, his/her dependent survivors, defined as their lawful spouse, enrolled domestic partner and/or eligible dependent children, according to the rules of the Fund, may continue the benefits they were receiving on the date of the retiree's death, provided they continue to timely remit the payments required (see Retiree Benefits Section). Dependent survivor coverage shall terminate upon any one of the following events: remarriage of the surviving spouse; marriage of surviving domestic partner; or domestic partner enters into another domestic partnership.

THIRD-PARTY REIMBURSEMENT/SUBROGATIONS

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

[A] To reimburse the Fund, to the extent benefits are paid by it, out of any money 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 on seeking recovery. The assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; 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.

Dental Benefits

DENTAL BENEFITS

You will be paid up to the scheduled allowance for dental work provided while you or an eligible dependent is covered, up to the maximum for the procedure listed in the dental schedule. In addition, if you use one of the participating dentists and the FASCC Benefit Fund is the primary coverage, the fees listed in the dental schedule will be accepted as payment in full for covered services.

The following conditions must be met for benefits to be payable:

- the claimant must be eligible for benefits at the time expenses are incurred;
- the expense is incurred when the service is performed, except in the case of:
    - dentures - when the final impression is taken;
    - crown or fixed bridgework - when preparation of the tooth is begun;
    - root canal therapy - when work on the tooth is completed;
- no changes have been made in the plan prior to the performance of the service that would change the allowance;
- total benefit payments for all treatment of a patient must not exceed the plan maximums;
- the allowance may be reduced by coordination of benefits as applicable.

Maximum Amount Payable: The maximum amount payable for each covered active member and his or her dependents for covered dental services will be $2,750 in any plan year (September 1st to August 31st) exclusive of orthodontic, implant and periodontic services which have separate maximums. The yearly maximum per person for covered periodontic work is $2,000. The lifetime maximum per person for orthodontia is $5,991. The lifetime maximum per person for implants is $3,500.

Note: All plan maximums are based on the Fund's Schedule of Dental Allowances.

The maximum for covered retirees in the Basic Plan is $500 per plan year (September 1st to August 31st) for the retiree and his or her eligible dependents combined.

Pre-Determination of Benefits: If your course of treatment is expected to cost more than $600, your dentist is required to complete a pre-determination request on the dental claim form and submit it with a properly mounted set of x-ray films for review by the Fund's Consultant Dentist. Pre-determination by the Fund's Consultant Dentist is limited to the approval of the course of treatment proposed; it does not include approval of payment for services not covered under

the Dental Plan, the patient's eligibility or guaranteed payment. Completed treatment amounting to $1,000 or more may require examination of the patient by the Fund's Consultant Dentist before payment is made. Your dentist should be familiar with this procedure. This process assures that both you and your dentist will know in advance what services are covered and just what part of the dentist's charges the FA Benefit Fund would pay.

Pre-determination is not intended to interfere with your dentist's professional judgment or to delay your dental care. Rather, this process permits a review of the proposed treatment in advance and allows for the resolution of any questions before, rather than after, the work has been done.

The FA Benefit Fund has the right to request that a patient undergo an oral examination to verify the treatment that is recommended in the pre-determination review.

Failure to comply with the pre-determination rules will result in forfeiture of benefits.

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

The attending dentist and the patient may still proceed with the original treatment plan regardless of the Fund's determination. However, reimbursement will be made at the level of the alternative.

For example, payment for a crown may not be made if an acceptable professional result can be obtained by filling the tooth. Payment will then be made as if the tooth were filled.

Obtaining Benefits: In order to obtain benefits, request the necessary dental claim form from the Fund office. Upon completion of treatment, have the dentist complete his or her portion of the claim form. You should then complete your portion of the claim form and mail it to the Third Party Administrator. If prolonged dental treatment is required, you should periodically submit claim forms to the Third Party Administrator for that portion of the treatment which has been completed. Payment of the claim will be made directly to you unless you use a participating dentist, then the payment will be made to the dentist. All claims must be submitted within one (1) year after the completion of the dental service in order to be considered for reimbursement.

Participating Dentist Program: The FA Benefit Fund provides for free choice of dentists. However, the Fund has made arrangements with many dentists who accept the fees listed in the dental schedule as payment in full when the Benefit Fund is the primary carrier. If you use a participating dentist and the Fund is the primary carrier, you will not have to pay for any services listed in the schedule up to the plan maximums. Payments will be made by the Fund directly to the dentist.

Participating dentists may charge you for services not covered by the plan if the annual maximum has been reached or the frequency limitation has been exceeded.

Dentists who specialize in orthodontia, periodontia, endodontia or oral surgery are listed separately from general dentists. This list will be revised from time to time by the Fund.

The list provides the names, addresses and telephone numbers of the dentists who are currently participating with the Fund's dental plan. These dentists have agreed to provide covered dental procedures at no out-of-pocket expense to Fund members and their eligible dependents. The list is provided as an informational service only for the convenience of covered members and eligible dependents. The Fund does not recommend the services of any particular dentist. The participating providers have been selected because they have agreed to accept the Fund's fee schedule as payment in full for covered services. If you or your eligible dependents are charged for any covered services by a participating provider, do not pay the charge and contact the Fund office immediately. The Fund requests that you report any irregularities, including rudeness, unsanitary conditions and difficulty in obtaining appointments at convenient hours to the Fund office.

Limitations and Exclusions:

Covered dental expenses shall not include expenses incurred for:

- Instruction for plaque control;
- Oral hygiene instruction;
- Bite registrations;
- Experimental or investigational dental services;
- Any services, supplies, or treatment unless prescribed by a legally qualified dentist or physician;
- Services rendered prior to the patient becoming eligible for benefits;
- Any dental procedure performed wholly or substantially for cosmetic reasons or without respect to congenital mouth form;
- Replacement of existing denture or partial denture more than once every five years;

- Placement of existing crown or fixed bridge more often than once every five years;
- Crowns, inlays, dentures bridgework or other prosthetic appliances installed or delivered more than 30 days after termination of coverage;
- Charges for crowns, inlays, dentures, bridges or other appliances to increase vertical dimension or reduce occlusion;
- Charges for multiple abutting of teeth or crowns, or teeth installed for clasping purposes only, or crowns and/or inlays installed as multiple abutments and splints to augment periodontal treatment;
- Duplicate prosthetic appliances;
- A prosthetic appliance, fixed or removable, used as an adjunct to periodontal care, unless it replaces a missing tooth;
- Charges for temporary crowns (unless tooth is fractured and only on anterior teeth), implants and bridges or dentures involving implants, or for temporary dental services which will be considered an integral part of the final dental service rather than a separate service;
- Dental service performed by a dentist in which the Fund experiences an instance of unsatisfactory documentation or recording of services which are deemed detrimental to the Fund or the patient;
- Most inclusive periodontal service includes all other services performed on the same date, in the same area and payment will be make for the all-inclusive service only; e.g., osseous surgery (ADA code 4260) and gigivectomy (ADA code 4210) performed on the same date, payment will be made for the all-inclusive osseous surgery only;
- Any benefit that is claimed after a period that exceeds one year from the completion of the dental services;
- Replacement of a lost or stolen appliance;
- Dental supplies or services for which benefits are provided at a Veteran's Administration hospital or clinic, or for dental supplies or services related to injury or disease covered by any Workers' Compensation law or charges for expenses which are reimbursable through "no fault" automobile insurance;
- Dental supplies or services furnished by or for the United States government or any other local governmental agency or where reimbursement is made elsewhere;
- Services where a charge is not incurred or payment is not required;
- Services performed by a member of your or your spouse's immediate family, unless proof of payment is provided for those services.

- Dental services or supplies not listed or not consistent with the Schedule of Allowance unless the Fund reviews the services and accepts the expenses as covered dental expenses. The covered dental expense for such services will be determined by the Fund and will be consistent with those listed in the Schedule of Allowance.

Schedule of Dental Allowances

Comprehensive benefits for eligible members, spouses, and dependent children. Pre-authorization required for dental services amounting to $600 or more.

MAXIMUM PER PLAN YEAR

Active Member: $2,750 per individual **Retired Member (Basic):** $500 per family
Retired Member (Enhanced Plan): $2,750 per individual

Special Benefits (in addition to Maximum per Plan Year) for Active Members and Retirees with Enhanced Plan

Periodontal Benefit: (codes 4210-4910) Up to $2,000 yearly maximum – Implant Benefit (codes 6010, 6040 & 6050 only) payable Up to $2,000 per tooth with a lifetime maximum of $3,500. Orthodontic Benefits: (codes 8080 or 8090), procedures 8462, 8660, 8670 and 8680). According to schedule up to $5,991 lifetime maximum.

PLAN YEAR: September 1 - August 31 **EFFECTIVE: September 1, 2015**

ADA	Description	Allowance	Freq.
0120*	Periodic Oral Examination	50.00	2/1
0140*	Oral Examination - Limited	60.00	2/1
0150*	Oral Examination - Comprehensive	70.00	1/1
0180	Comprehensive periodontal evaluation - new or established patient	70.00	2/1
0210	Intraoral - complete series - including bitewings (once every 3 plan years)	74.00	1/3
0220	Intraoral, Periapical, first film	13.00	
0230	Intraoral, Periapical, each additional film	12.00	
0240	Intraoral, Occlusal film	25.00	2/3
0270	Bitewings, single film	12.00	2/1
0272	Bitewings, two films	22.00	2/1
0274	Bitewings, four films	33.00	2/1
0290	Survey Film, face and skull	18.00	1/1
0330	Panoramic film (once every 3 plan years)	70.00	1/3

0340	Cephalometric Film	56.00	1/1
0460	Pulp Vitality Test	41.00	1/1
0470	Diagnostic Casts, upper and/or lower	37.00	1/L
1110	Prophylaxis - Adult	75.00	2/1
1120	Prophylaxis - Child - under 12 years of age	50.00	2/1
1206	Flouride - Child - under 12 years of age	23.00	2/1
1208	Flouride - Adult	21.00	2/1
1351	Sealants, for newly erupted molars only - per tooth, for dependent children to age 16	40.00	2/L
1510	Space Maintainer - Fixed - Unilateral	75.00	1/L
1515	Space Maintainer - Fixed - Bilateral	120.00	1/L
1520	Space Maintainer - Removable - Unilateral	95.00	1/L
1525	Space Maintainer - Removable - Bilateral	150.00	1/L
1550	Recementation of Space Maintainer	24.00	1/1
2140	Amalgam - 1 Surface, primary or permanent	70.00	1/1
2150	Amalgam - 2 Surfaces, primary or permanent	95.00	1/1
2160	Amalgam - 3 Surfaces, primary or permanent	115.00	1/1
2161	Amalgam - 4 or more Surfaces, primary or permanent	135.00	1/1
2330	Resin - 1 Surface, Anterior	100.00	1/1
2331	Resin - 2 Surfaces, Anterior	125.00	1/1
2332	Resin - 3 Surfaces, Anterior	165.00	1/1
2335	Resin - 4 or more Surfaces or involving Incisal Angle (anterior)	200.00	1/1
2391	Resin-based composite - 1 Surface, Posterior	100.00	1/1
2392	Resin-based composite -2 Surfaces, Posterior	125.00	1/1

2393	Resin-based composite - 3 Surfaces, Posterior	165.00	1/1
2394	Resin-based composite - 4 or more Surfaces, Posterior	200.00	1/1
2510	Inlay - Metallic - 1 Surface	120.00	1/5
2520	Inlay - Metallic - 2 Surfaces	195.00	1/5
2530	Inlay - Metallic - 3 Surfaces	240.00	1/5
2542	Onlay - Metallic - 2 Surfaces	150.00	1/5
2543	Onlay - Metallic - 3 Surfaces	400.00	1/5
2544	Onlay - Metallic - 4 or more Surfaces	400.00	1/5
2610	Inlay - Porcelain/Ceramic - 1 Surface	150.00	1/5
2620	Inlay - Porcelain/Ceramic - 2 Surfaces	210.00	1/5
2630	Inlay - Porcelain/Ceramic - 3 Surfaces	450.00	1/5
2642	Onlay - Porcelain/Ceramic - 2 Surfaces	225.00	1/5
2643	Onlay - Porcelain/Ceramic - 3 Surfaces	325.00	1/5
2644	Onlay - Porcelain/Ceramic - 4 or more Surfaces	475.00	1/5
2662	Onlay - Composite/Resin - 2 Surfaces (Lab)	175.00	1/5
2663	Onlay - Composite/Resin - 3 Surfaces (Lab)	200.00	1/5
2664	Onlay - Composit/Resin - 4 or more Surfaces	475.00	1/5
2710	Crown - Resin (laboratory)	150.00	1/5
2720	Crown - Resin with high noble metal	400.00	1/5
2721	Crown - Resin with predominantly base metal	400.00	1/5
2722	Crown - Resin with noble Metal	400.00	1/5
2740	Crown - Porcelain/Ceramic Substrate	450.00	1/5
2750	Crown - Porcelain fused to high noble metal	700.00	1/5
2751	Crown - Porcelain fused to predominantly base metal	700.00	1/5
2752	Crown - Porcelain fused to noble metal	700.00	1/5
2790	Crown - Full Cast high noble metal	500.00	1/5
2791	Crown - Full Cast predominantly base metal	500.00	1/5
2792	Crown - Full Cast noble metal	500.00	1/5
2910	Recement inlay	45.00	1/1
2920	Recement crown	55.00	1/1
2940	Sedative filling	60.00	1/L

2950	Crown Buildup, including any pins	120.00	1/L
2951	Pin Retention-per tooth	25.00	1/L
2952	Cast post and core in addition to crown	225.00	1/5
2954	Prefabricated post and core in add. to crown	200.00	1/5
2960	Labial Vaneer (laminate) - chairside	325.00	1/3
2961	Labial Vaneer (resin laminate) - lab	250.00	1/5
2962	Labial Vaneer (porcelain laminate) - lab	700.00	1/5
2970	Temporary Crown (fractured tooth) - upper and lower anterior teeth only	75.00	1/L
3110	Pulp cap - direct (exclud. final restoration)	18.00	1/1
3120	Pulp cap - indirect (exclud. final restoration)	25.00	1/1
3220	Therapeutic pulpotomy (exclud. final restoration)	76.00	1/L
3310	Anterior Root Canal (exclud. final restoration)	500.00	1/L
3320	Bicuspid Root Canal (exclud. final restoration)	700.00	1/L
3330	Molar Root Canal (exclud. final restoration)	800.00	1/L
3346	Retreatment-RCT (Anterior)	350.00	1/L
3347	Retreatment-RCT (Bicuspid)	450.00	1/L
3348	Retreatment-RCT (Molar)	800.00	1/L
3410	Apicoectomy/Periradicular surgery - anterior	350.00	1/L
3421	Apicoectomy/Periradicular surgery - bicuspid (1st root)	425.00	1/L
3425	Apicoectomy/Periradicular surgery - molar (1st root)	475.00	1/L
3426	Apicoectomy/ Periradicular surgery - each additional root	200.00	1/L
3430	Retrograde filling - per root	112.00	1/L
3920	Hemisection (including any root removal) - not including RCT	50.00	1/L
4210	Gingivectomy or Gingivoplasty - 4 or more teeth per quadrant	215.00	1/4
4211	Gingivectomy or Gingivoplasty - 1-3 teeth per quadrant	129.00	1/4
4249	Crown lengthening, hard or soft tissue	340.00	1/4
4260	Osseous Surgery - 4 or more teeth per quadrant	800.00	1/4
4261	Osseous Surgery - 1-3 teeth per quadrant	600.00	1/4

4263	Bone replacement graft - 1st site in quadrant	300.00	1/4
4264	Bone replacement graft - each add'l site in quadrant	220.00	1/4
4270	Pedicle Soft Tissue Graft	250.00	1/4
4271	Free Soft Tissue Graft (including donor site)	512.00	1/4
4341	Periodontal Scaling & Root Planning - 4 or more teethper quadrant	75.00	4/1
4342	Periodontal Scaling & Root Planning - 1-3 teeth per quadrant	45.00	4/1
4381	Chemotherapeutic agents	50.00	4/1
4910	Periodontal Maintenance Procedures (following active therapy)	125.00	2/1
5110	Complete upper dentures	900.00	1/5
5120	Complete lower dentures	900.00	1/5
5130	Immediate upper dentures	900.00	1/5
5140	Immediate lower dentures	900.00	1/5
5211	Partial upper denture - resin base (including clasps, rests & teeth)	525.00	1/5
5212	Partial lower denture - resin base (including clasps, rests & teeth)	525.00	1/5
5213	Partial upper denture - cast metal base w/resin saddles (including clasps, rests & teeth)	757.00	1/5
5214	Partial lower denture - cast metal base w/resin saddles (including clasps, rests & teeth)	757.00	1/5
5281	Removable unilateral partial denture - one piece cast metal (including clasps & pontics)	210.00	1/5
5410	Adjust Complete Denture (upper)	15.00	1/1
5411	Adjust Complete Denture (lower)	15.00	1/1
5421	Adjustment, Partial Denture (upper)	15.00	1/1
5422	Adjustment, Partial Denture (lower)	15.00	1/1
5510	Repair Broken Complete Denture Base	35.00	1/1
5520	Replace Missing or Broken Teeth - Complete Denture, first tooth	35.00	1/1
5610	Repair resin saddle or base	88.00	1/1

5620	Repair cast framework	74.00	1/1
5630	Repair or replace broken clasp	118.00	1/1
5640	Replace broken teeth - per tooth	68.00	1/1
5650	Add tooth to existing partial denture	65.00	1/L
5660	Add clasp to existing partial denture	56.00	1/L
5730	Reline complete upper denture (chairside)	65.00	1/3
5731	Reline complete lower denture (chairside)	65.00	1/3
5740	Reline upper partial denture (chairside)	65.00	1/3
5741	Reline lower partial denture (chairside)	65.00	1/3
5750	Reline complete upper denture (laboratory)	115.00	1/3
5751	Reline complete lower denture (laboratory)	115.00	1/3
5760	Reline upper partial denture (laboratory)	115.00	1/3
5761	Reline lower partial denture (laboratory)	115.00	1/3
5820	Temporary Partial - Stayplate Denture (upper)	125.00	1/5
5821	Temporary Partial - Stayplate Denture (lower)	150.00	1/5
5850	Tissue Conditioning - per denture	45.00	1/3
5860	Overdenture, complete, by report	375.00	1/5
6010	Surgical placement of implant body: endosteal implant	**	
6040	Surgical placement: eposteal implant	**	
6050	Surgical placement: transosteal implant	**	
6053	Implant/abutment supported removable denture for completely edentulous arch	114.00	1/5
6054	Implant/abutment supported removable denture for partially edentulous arch	114.00	1/5
6056	Prefabricated abutment	175.00	1/5
6057	Custom abutment	850.00	1/5
6058	Abutment supported porcelain/ceramic crown	850.00	1/5
6059	Abutment supported porcelain fused to metal crown (high noble metal)	850.00	1/5
6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	850.00	1/5
6061	Abutment supported porcelain fused to metal crown (noble metal)	850.00	1/5

6062	Abutment supported cast metal crown (high noble metal)	850.00	1/5
6063	Abutment supported cast metal crown (predominantly base metal)	850.00	1/5
6064	Abutment supported cast metal crown (noble metal)	850.00	1/5
6065	Implant supported porcelain/ceramic crown	850.00	1/5
6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	850.00	1/5
6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	850.00	1/5
6068	Abutment supported retainer for porcelain/ceramic FPD	850.00	1/5
6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	850.00	1/5
6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	850.00	1/5
6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	850.00	1/5
6072	Abutment supported retainer for cast metal FPD (high noble metal)	850.00	1/5
6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	850.00	1/5
6074	Abutment supported retainer for cast metal FPD (noble metal)	850.00	1/5
6075	Implant supported retainer for ceramic FPD	850.00	1/5
6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	850.00	1/5
6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	850.00	1/5
6210	Pontic - cast high noble metal	335.00	1/5
6211	Pontic - cast predominantly base metal	335.00	1/5
6212	Pontic - cast noble metal	335.00	1/5
6240	Pontic - porcelain fused to high noble metal	700.00	1/5
6241	Pontic - porcelain fused to predominantly base metal	700.00	1/5

6242	Pontic - porcelain fused to noble metal	700.00	1/5
6250	Pontic - resin with high noble metal	355.00	1/5
6251	Pontic - resin with predominantly base metal	355.00	1/5
6252	Pontic - resin with noble metal	355.00	1/5
6545	Retainer - cast metal for acid etched fixed prosthesis	165.00	1/5
6610	Repair broken facing with slotted or other facing	56.00	1/1
6720	Crown - resin with high noble metal	355.00	1/5
6721	Crown - resin with predominantly base metal	355.00	1/5
6722	Crown - resin with noble metal	355.00	1/5
6750	Crown - porcelain fused to high noble metal	700.00	1/5
6751	Crown - porcelain fused to predominantly base metal	700.00	1/5
6752	Crown - porcelain fused to noble metal	700.00	1/5
6780	Crown - 3/4 cast high noble metal	390.00	1/5
6790	Crown - full cast high noble metal	410.00	1/5
6791	Crown - full cast predominantly base metal	355.00	1/5
6792	Crown - full cast noble metal	355.00	1/5
6930	Recement Bridge	75.00	1/1
6940	Stress Breaker	110.00	1/5
6950	Precision Attachment	125.00	1/5
6972	Prefabricated post and core in addition to bridge retainer	85.00	1/5
7111	Extraction - coronal remnants - deciduous tooth	114.00	1/L
7140	Extraction - erupted tooth or exposed root	130.00	1/L
7210	Surgical removal of erupted tooth requiring elevation mucoperiosteal flap and removal of bone and/or section of tooth	200.00	1/L
7220	Removal of impacted tooth - soft tissue	250.00	1/L
7230	Removal of impacted tooth - partially bony	350.00	1/L
7240	Removal of impacted tooth - completely bony	400.00	1/L
7241	Removal of impacted tooth - completely bony with unusual surgical complications	350.00	1/L
7250	Surgical removal of residual roots (cutting procedure)	200.00	1/L

7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons including orthodontic attachments)	250.00	1/L
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	100.00	1/L
7285	Biopsy of oral tissue - hard	250.00	1/1
7286	Biopsy of oral tissue - soft	250.00	1/1
7310	Alveoloplasty in conjunction with extractions - per quadrant	98.00	1/L
7320	Alveoloplasty not in conjunction with extractions - per quadrant	125.00	1/5
7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm	250.00	1/L
7451	Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	150.00	1/L
7460	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	50.00	1/L
7461	Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	75.00	1/L
7510	Incision and drainage of abscess - intraoral soft tissue	150.00	1/1
7520	Incision and drainage of abscess - extraoral soft tissue	45.00	1/1
7953	Bone Replacement graft for ridge preservation - per site	300.00	1/4
8080	Comprehensive Orthodontic Treatment of the adolescent dentition (Once Lifetime)	900.00	1/L
8090	Comprehensive Orthodontic Treatment of the adult dentition (Once Lifetime)	900.00	1/L
8220	Fixed appliance therapy (Once Lifetime)	300.00	1/L
8462	Orthodontic passive treatment (12 Months Lifetime)	55.00	12/L
8660	Pre-Orthodontic treatment visit	131.00	1/L
8670	Periodic orthodontic treatment (24 Months Lifetime)	150.00	24/L

8680	Orthodontic Retention (removal of appliances, construction & placement of retainers - 1 each - top & bottom)	200.00	1/L
9110	Palliative (emergency) treatment of dental pain - minor procedures	60.00	1/1
9220	General Anesthesia - first 30 minutes	250.00	/Session
9221	General Anesthesia - each additional 15 minutes (maximum 30 minutes)	100.00	/Session
9241	Intravenous conscious sedation/analgesia - 1st 30 minutes	250.00	/Session
9242	Intravenous conscious sedation/analgesia - each additional 15 minutes (maximum 30 minutes)	100.00	/Session
9310	Professional Consultation by Specialist	100.00	2/1
9940	Occlusal guards	223.00	1/L
9951	Occlusal Adjustment (limited)	60.00	1/4
9952	Occlusal Adjustment (complete)	170.00	1/4

Benefits listed under S.A. will be available when services are rendered by board eligible or board certified specialists.

Freq. = Frequency Limit Abbreviations:

1/1	Once Per Plan Year
2/1	Two Times Per Plan Year
4/1	Four Treatments Per Plan Year
1/3	Once Per 3 Plan Years
2/3	Two Times Per 3 Plan Years
1/4	Once Per 4 Plan Years
1/5	Once Per 5 Plan Years
1/L	Once Per Patient Lifetime
2/L	Twice Per Patient Lifetime (once for primary tooth, once for permanent tooth)
12/L	Twelve Times Per Patient Lifetime
24/L	Twenty-Four Times Per Patient Lifetime

*"For out of network services rendered to eligible dependent children under age 19, these procedures, will be reimbursed at charges up to 100% of the reasonable and customary allowance at the same frequency limitation

** Implants: Payable up to $2000 per tooth with a lifetime maximum of $3500.

OPTICAL BENEFIT

Active members and their eligible dependents as well as retirees purchasing the Enhanced plan are entitled to optical benefits once during each plan year. (September 1st – August 31st). (Retired members in the Basic Plan are eligible once every two years.) You have the option of choosing from either one or two of the following optical benefits under this program.

1. At participating providers, you are entitled to a paid-in-full benefit for a comprehensive eye exam including a glaucoma test and one pair of eyeglasses or prescription sunglasses (lenses and frame), or the benefit may be used for standard daily wear, disposable contact lenses or planned replacement contact lenses. Additional frame selections and many different lenses and coatings are also available at participating providers at discounted prices. Contact the Fund office or check the Fund's website for a recent list of copays.

   All frames and lenses through participating providers have a one year 100% replacement guarantee if damaged or broken due to defects in manufacturing.

2. At non-participating providers, reimbursement will be made directly to you for actual expenses not to exceed $10 for an exam and up to $35 for materials (frames, lenses, contacts).*

Obtaining Benefits: Call the Fund office, or check the Fund's website, for a list of participating providers or for a Direct Reimbursement Claim Form if you use a non-participating provider.

In order for a dependent full-time student between the ages of 19 and 25 to obtain optical benefits, proof of full-time student status must be submitted every semester. Verification of student status forms may be obtained at the Fund office.

If you choose a participating provider, call the provider's office directly to schedule an appointment. Identify yourself as an FASCC Benefit Fund member or dependent. The provider's office will verify your eligibility for services.

*If you choose to use a non-participating provider, return your Direct Reimbursement Claim Form, with receipts attached to the Fund's optical benefit administrator at the address on the claim form. An indemnity payment will be made directly to you.

General Limitations: When you go to a non-participating provider, you must have the provider complete the Direct Reimbursement Claim Form. The examination, lenses and frames must be billed at the same time, on one claim form during each plan year (Sept. 1 - Aug. 31).

In order for you to make the best possible use of your optical benefit, please keep in mind that partial usage of the benefit is considered the same as full usage. If, for example, you file a claim for an eye examination only, or just for the repair of frames, you will not be entitled to receive the benefit for another plan year.

The three parts of the benefit (examination, lenses and frame) cannot be split between participating providers and non-participating providers. You must use one option or the other for all three parts.

Prescription Drug Copay Reimbursement Benefit

PRESCRIPTION COPAYMENT REIMBURSEMENT

This benefit is provided to reimburse the copayments incurred by covered members and their eligible dependents for prescription drugs. Effective with prescriptions filled and paid for on and after January 1, 2014, the Fund will reimburse the copayment incurred by the member and/or his/her eligible dependents, up to $500 per calendar year (an increase from $450!) plus an additional one percent of the copayment per eligible prescription submitted over $500.00. Prescriptions will be adjudicated in the order they are filled chronologically. Eligible dependents are dependents who are deemed eligible for FA Benefit Fund benefits.

A dependent can be eligible for EMHP coverage but not necessarily eligible for Fund benefits (e.g., the Fund does not cover adult children up to age 26).

Prescription drugs covered under this program must have been prescribed by a medical doctor, osteopath or dentist and dispensed by a licensed pharmacist. Prescription services which are covered include:

- Prescription which require compounding;
- Prescriptions for legend drugs;
- Insulin on prescriptions;
- Allergic solutions or extracts normally purchased at a pharmacy authorized by a doctor;
- Prescription vitamins;
- Birth control pills.

Obtaining Benefits: In order to obtain benefits, submit a claim form (obtained from the Fund office or downloaded from our website) along with your pharmacy printout or annual statement from your prescription drug carrier, to the Fund office. The copayment amount must be indicated on the pharmacy's printout. All claim forms must contain a total dollar amount or the claim may be returned to you without payment. All items listed will be subject to verification.

Submit your completed and signed form only after you have accumulated a minimum amount of $500 for prescription drug copayments. If you do not meet the minimum prior to the end of the year, submit your claim for whatever the amount below that figure after the last day of the calendar year. Your prescription drug claim must be submitted no later than April 30th of the year following the year charges were incurred in order to be eligible for coverage.

(Example: Covered expenses incurred from 1/1/15 through 12/31/15 must be claimed no later than 4/30/16.)

Note: The same rules and regulations governing Suffolk County's primary prescription drug plan apply. The Fund does not cover prescription costs incurred by members beyond the amount payable by your primary prescription drug plan. If for some reason you had to pay full price for a prescription (perhaps your card was unavailable or you were out-of-state), you must first submit the costs to your primary prescription plan prior to claiming reimbursement by the Fund. Do not submit your claim to the Fund unless all costs are supported by proof. Submissions at a later date will not be reconsidered for payments.

Limitations: Only one claim per family per calendar year is eligible.

Individual records of prescriptions not accompanied by a pharmacy printout or a copy of a receipt will not be honored.

The Fund prescription drug coverage is secondary to your primary prescription drug coverage. Example: Employee Medical Health Plan of Suffolk County, HMO or spouse's coverage.

No coverage is provided for over the counter drugs, vitamins, diet supplements, etc., which, even though prescribed by physician, can be legally purchased without a prescription; allergy prescriptions unable to be filled at a licensed pharmacy or drugs prescribed for cosmetic purposes.

Hearing Aid Benefit

HEARING AID BENEFIT

Active members, retirees and eligible dependents may be reimbursed up to $1,500* for the purchase of a hearing aid once every rolling 36 months. This includes charges for fitting and the cost of the hearing aid when recommended by a physician or audiologist. This amount is the total allowance for reimbursement without the per ear limitation. The Fund will not pay for repairs to hearing aids, non-durable equipment such as batteries, or appliances or expenses not recommended or approved by a physician or audiologist. For eligible dependents of members age 12 and under, the frequency information is once every 24 months, provided the existing hearing aid can no longer compensate for the child's hearing loss.

*Basic Retirees will remain at $1,000 every rolling thirty-six (36) months.

Obtaining Benefits: In order to obtain benefits download the claim form from our website, www.fascc.org, or call the Fund office at 631-732-6500 for a claim form and submit along with EOB (Explanation of Benefits) from Empire Blue Cross Blue Shield.

All hearing aid claims must be filed within 12 months from the purchase of the hearing aid.

Dependent Care Benefit

NEW DEPENDENT CHILD

(For active members only)

Effective January 1, 2014, the New Dependent Benefit will reimburse up to $500.00 to a covered member for the birth or adoption of a new dependent child to help defray the costs of caring for a new dependent. If you have multiple births, you will receive multiple benefits. Download the claim form from our website, www.fascc.org, or call the Benefit Fund office 631-732-6500 for a claim form and submit along with the copies of child's birth or adoption certificate, Social Security card and copies of receipts for expenses incurred for your new dependent child.

All new dependent child claims must be filed within 12 months from the birth or adoption of your child.

FINANCIAL COUNSELING BENEFIT

WHO IS ELIGIBLE?

If you are eligible for Faculty Association of Suffolk Community College Benefit Fund benefits, either as a full-time member of the Faculty Association or the Guild of Administrative Officers, or you are a retiree enrolled in and paying for either the enhanced or enhanced plus plan, you are eligible to participate in the financial counseling program.

WHAT IS THE BENEFIT?

The Fund provides for financial consultations and financial education through the investment advisory firm of Stacey Braun Associates, Inc. Financial topics that are covered include but are not limited to:

- Retirement Planning
- College Funding
- Investment Planning
- Pension/IRA Rollovers
- Basic Estate Planning
- Life, Disability, and Long Term Care Insurance
- Tax Planning

WHAT SERVICES ARE AVAILABLE TO ELIGIBLE MEMBERS?

- One and one-half hours of financial consultations each plan year*.
- Unlimited access to Stacey Braun's proprietary financial website.
- Unlimited use of Stacey Braun's e-mail help-desk.
- Periodic Financial Education Seminars.

* Consultations are held at the Benefit Fund office or campus locations on predetermined dates.

WHAT ARE THE COSTS?

- One and one-half hours of financial consultations each plan year – NO COST TO ELIGIBLE MEMBERS.*
- Unlimited access to Stacey Braun's proprietary financial website – NO COST TO ELIGIBLE MEMBERS.*
- Unlimited use of Stacey Braun's e-mail help-desk – NO COST TO ELIGIBLE MEMBERS.
- Periodic Financial Education Seminars – NO COST TO ELIGIBLE MEMBERS.

*Stacey Braun Associates, Inc. is not compensated by any of the products that they may recommend.

HOW TO UTILIZE THE BENEFIT:

To utilize this benefit contact Stacey Braun at 1-888-949-1925 or to access the website log on to www.staceybraun.com. Use your zip code as your temporary password and the first initial of your first name, the first four letters of your last name and the last four numbers of your Social Security number (no spaces) as your ID.

HEALTH ADVOCATE PROGRAM

The Faculty Association of Suffolk Community College Benefit Fund has retained the services of Health Advocate, Inc. to provide a program designed to help you and your families handle healthcare and insurance related issues by cutting through the red tape and barriers that so often create frustration and problems.

Who is Covered Health Advocate will provide services to all eligible, full-time, active members of the Benefit Fund, retired members of the FASCC who enroll in and pay for one of the enhanced self-pay retiree plans of the Fund as well as the Active and/or Retired Member's spouse/domestic partner, dependent children, parents and parents-in-law (collectively referred to in this section as "Eligible Members").

What are the Benefits Health Advocate will help you and your families make more informed decisions about health care. A Health Advocate nurse will answer your questions, do the research, provide you the options and follow up with you. The following services are provided to Eligible Members:

The Personal Health Advocate is typically a Registered Nurse, assigned to serve the subscriber as soon as he/she calls to access services. Personal Health Advocates handle a range of issues as Eligible Members seek healthcare services and interact with providers and insurers.

- **24/7 HelpNet:** Health Advocate's business hours for reaching a live person are 8:00 a.m. to 7:00 p.m. Eastern Standard Time. After hours, Eligible Members can leave a message and Health Advocate will return the call the next business day. In a non-medical emergency, Eligible Members may use the beeper number provided to page an "on-call" Health Advocate representative.

- **Care Coordination:** The Personal Health Advocate helps Eligible Members coordinate care among physicians and medical institutions.

- **Medical Director and Administrative Support:** Physicians and administrative staff support the Personal Health Advocates.

Health Cost Estimator™ Health Advocate has made available to Eligible Members a healthcare pricing tool – Health cost Estimator plus+ (HCE+) in an attempt to address the critical need for transparency in medical costs. HCE+ produces detailed cost estimates customized to each individual based on their specific health issues, location and health plan. In order to take advantage of this service, Eligible Members must call Health Advocate first at 866.799.2691. A Personal Health Advocate will then assess the caller's needs and provide the average cost* of a medical service for their geographic area, including the cost difference

between in- and out-of-network care.

* The Health Cost Estimator™ provides only an estimate. It is not specific to any health plan offered by Suffolk County (i.e., it does not know how much the EMHP will pay for the service you are calling about).

Benefits Advantage™

- **Claims Assistance*:** Personal Health Advocates help sort out and solve claims and related paperwork problems and assist Eligible Members with coverage and benefits issues.

* Health Advocate does not deliver medical care nor tell Eligible Members what to do. Health Advocate does not replace the Employee Benefit Unit (EBU) in Suffolk County, customer service through Empire Blue Cross/Blue Shield or your HMO provider, nor is it a nurse hot-line for emergencies.

- **Fee Negotiation:** When necessary, Health Advocate can attempt to negotiate fees with healthcare providers and review questionable bills to catch duplicative and/or erroneous charges.

- **Grievance Advice:** Health Advocate will provide advice and/or assistance to Subscribers when filing a complaint or grievance. However, any costs and expenses incurred by Health Advocate in connection with representation at appeals hearings will be billed directly to the Eligible Member, at an hourly rate.

- **Coverage Advantage™**: The Personal Health Advocate can help Eligible Members through the coverage review process. We can also assist in identifying alternative coverage options when necessary.

- **RxAdvocate™:** The Personal Health Advocate can assist Eligible Members with prescription drug issues including formulary and benefit questions.

Physician Locator: Personal Health Advocates can help Eligible Members identify physicians, hospitals, dentists and other healthcare providers for needed services.

Advocates of Excellence: Personal Health Advocates can help identify top medical institutions, Centers of Excellence and medical providers to assist Eligible Members in need of complex medical care. Our Personal Health Advocates can also help Eligible Members schedule appointments with these providers, as required.

Health Advocate CareQuest: This Service locates resources and makes arrangements for Eligible Members in need of special services that typically fall outside the realm of traditional healthcare benefits. The Eligible Member is responsible for payment for any services that they use beyond what may be covered by their health insurance plan.

Health Advocate does not deliver medical care nor tell Eligible Members what to do. Health Advocate does not replace the Employee Benefit Unit (EBU) in Suffolk County, customer service through Empire Blue Cross/Blue Shield or your HMO provider, nor is it a nurse hot-line for emergencies.

How are Benefits Obtained: Simply call Health Advocate at 1-866-695-8622. There are no enrollment forms. When you call, Health Advocate and require service, they will ask you to complete a Medical Information Release Form. Please be assured that all your information will be kept strictly confidential by Health Advocate and your privacy will be protected.

Life Insurance Benefit

LIFE INSURANCE/A&D BENEFIT

(For active members only)

In the event of your death from any cause, at a time when you are eligible for benefits, your designated beneficiary will receive $10,000. This benefit is underwritten by a life insurance company.

Designation of Beneficiary: You may name anyone you wish as your beneficiary on a form provided for that purpose by the Fund office. You may change your designation at any time by signing the appropriate form and filing it with the Fund office. Payment will be made in a lump sum to your designated beneficiary or beneficiaries in equal shares unless you request otherwise when you file your beneficiary form. You may name a contingent beneficiary who will receive your life insurance if all the primary beneficiaries die before you.

If you have not named a beneficiary, the insurance company will pay your estate. It may, however, pay your surviving relatives as follows:

- a) all to your surviving spouse;
- b) if your spouse does not survive you, in equal shares to your surviving children; or
- c) if no children survive you, in equal shares to your surviving parents. If the beneficiary is a minor who does not have a legal guardian, the insurance company may, until a guardian is appointed, pay the person it deems to be caring and supporting him or her. Such payments will be made in monthly installments of not more than $50.00.

Termination: In the event your employment ends or you are no longer eligible for benefits under the FA Benefit Fund, coverage will cease as previously described. However, you have the right to convert to an individual policy. Please contact the Fund office if you wish to exercise this option.

Accidental Death or Dismemberment (AD&D): In the event of your death from an accident or an accidental dismemberment, you or your beneficiary can receive benefits from this coverage. The loss must occur within 90 days of the accident. Benefits are paid based on the following schedule:

Accidental death	$10,000
Accidental loss of both hands, both feet, the sight of both eyes, or any combination of these	$10,000
Accidental loss of one hand, one foot, or the sight of one eye	$5,000

Limitations: No payment will be made for an accidental death or accidental dismemberment resulting from or caused directly, wholly or partly, by:

- intentional self-destruction or intentional self-inflicted injury, while sane or insane, or
- participation in the commission of a crime, or
- war or an act of war, or service in any military, naval or air organization of any country while such country is engaged in war, counterinsurgency operations or a policing type of activity.

Obtaining Benefits: In order to obtain these benefits, you or your beneficiary should contact the Fund office for the appropriate form. This form should be submitted, along with a certified copy of the death certificate or physician's verification of the accidental loss, to the insurance company.

Burial Benefit

BURIAL BENEFIT

For active members or members' spouses and domestic partners only)

The FA Benefit Fund provides a $1,000 benefit to help defray the funeral expenses from the death of the member or the member's spouse or domestic partner. In the case of a married member, this benefit will be paid to the surviving spouse or registered domestic partner unless a signed beneficiary form naming another beneficiary is on file with the Fund office. In the case of a single member, the benefit will be payable to the member's beneficiary. Obtain a beneficiary form from the Fund office. Single members must file a designation of beneficiary form in order for this benefit to be payable.

Limitations: Covered members are those as defined as such by the Fund and include members on a paid leave of absence.

The member will be the beneficiary upon the death of his or her spouse. The member's spouse will be the beneficiary upon the death of a member unless a signed form naming another beneficiary is on file with the Fund office.

Obtaining Benefits: Submit a certified copy of the death certificate to the Fund office, along with a note listing the member's name and Social Security number in order to receive benefits. The death certificate must be sent to the Fund office within 12 months from the date of death in order for this benefit to be payable.

RETIREE BENEFITS

Eligibility: In order to qualify for FA Benefit Fund Retiree Benefits, you must meet the first requirement, and either 2A, 2B or 2C listed below:

1) You must be receiving or be entitled to receive a monthly pension from a New York State retirement system or the New York State Optional Retirement Program (e.g., TIAA-CREF.).

and

2A) You must have at least 10 years of full-time or job share employment with Suffolk County and you leave employment before age 55 or pursuant to New York State laws governing retirement eligibility;

or

2B) You have at least 10 years of full-time or job share employment with Suffolk County and you leave employment on or after age 55;

or

2C) You retire pursuant to any early retirement incentive.

Disability Retirement: In the case of an ordinary (not work-related) disability retirement, the age requirement is waived, but you must meet the minimum service requirement. In the case of a disability retirement resulting from work-related illness or injury, the age requirement and the minimum service requirements are waived.

While awaiting or whether or not your disability retirement is granted, and while you are not retired, you must continue to pay COBRA premiums in order to be eligible to continue Fund benefits into your retirement. If your disability retirement is granted, then your self-pay COBRA premiums will be adjusted retroactively to the effective date of your disability retirement. You may receive a refund if the COBRA rates exceeded the self-pay rates. If the disability retirement is not granted then you must be eligible as outlined above, and retire, in order to continue Fund benefits on a self-pay basis.

Enrollment Required for Retiree Benefits: In addition, you must complete a retiree enrollment form and return it the Fund office within sixty (60) days of your retirement date. This enrollment form will indicate the coverage level at which you choose to participate for the next Fund fiscal year (September 1 to August 31).

Eligibility for dependents of retirees and benefits available will be based on the coverage opted by you on the retiree enrollment form within sixty (60) days of your retirement date. In addition, note that you, as a retiree, may enroll for one (1) individual plan, covering yourself only; or two (2) individual plans, covering you and your spouse/enrolled domestic partner only; or one (1) family plan, covering you and all your eligible dependents. However, if you, as a retired member, are married to, or

in a domestic partnership with, another retired member, you can choose either one (1) individual plan each or one (1) family plan for both. You may not each opt for two (2) individuals plans. If enhanced coverage is purchased only for you, you will not be permitted to elect coverage for your dependents at a later date.

Covered Benefits: Eligible retirees will be provided with the following two options of benefits coverage under the Fund:

- The Enhanced Plan allows you to obtain the active member's level of benefits for dental, hearing aid, prescription drug copay reimbursement, optical care and financial counseling. A self-pay premium is required for this level of coverage.

- The Enhanced Plus Plan allows you to enroll in the Fund legal services plan, in addition to the active member's level of benefits for dental, hearing aid, prescription drug copay reimbursement, optical care and financial counseling. An additional yearly payment is required for this level of coverage above the Enhanced Plan payment.

Retirees who opt for coverage in the Enhanced Plus Plan will be provided a yearly opportunity during the month of August to move down to the Enhanced Plan. The effective date for the lesser coverage is September 1.

Eligibility for dependents of retirees is based on the coverage opted by the retiree on the enrollment form.

If Enhanced coverage was purchased only for the retiree, then any lesser level of coverage chosen at a later time will be provided for the retiree only. The retiree's eligible dependents will have no coverage.

Obtaining Coverage: Coverage for either the Enhanced Plan requires timely payment of the premium. The premium for these plans may change from year to year. Discounted rates are also available depending on payment frequency. Rates and the discount schedule may be obtained by calling the Fund office at 631-732-6500.

If you elect to buy the coverage, you must enroll and commit to a payment schedule for at least a full plan year (from September 1 to August 31), except in the case of mid-year retirement. If you elect to enroll in one of the enhanced plans and do not pay the cost of same for the plan year, your coverage will terminate and you will not be entitled to resume participation in any retiree plan of benefits offered by the Fund, ever.

If a retiree dies within the first 15 days of a plan year and no benefits are claimed, the Fund will reimburse the retiree's full premium paid by the retiree to the first surviving class of the following classes of successive preference beneficiaries: the

deceased retiree's a) widow/widower or enrolled domestic partner; b) surviving children; c) estate.

Retired Members Married To Active Members

If, upon your retirement, you are eligible to receive Fund coverage as a dependent spouse of an active member, at no cost to you, then your time to elect retiree benefits is deferred until such time as your spouse/active member retires, resigns or dies.

MEMBERS WHO RETIRED BEFORE 9/1/99:

Covered Benefits: Members who retired before 9/1/99 were given the additional option of the Basic Plan, which provides dental coverage under the Fund's schedule for you and your dependents up to a total reimbursement of $500 per family per plan year; optical care every two plan years; and the active hearing aid reimbursement program. Coverage for these benefits require no contribution from you.

Eligible retirees who enrolled in either the Enhanced Plus or Enhanced Plan will be provided yearly opportunity during the month of August to move down to lesser coverage. The effective date for lesser coverage is September 1. Any retiree who chooses to move down to the Basic Plan may never again opt to purchase either of the enhanced plans.

If you elected to enroll in one of the enhanced plans and do not pay the cost of same for the plan year, your coverage will terminate and you will not be entitled to resume participation in the any retiree plan, including the Basic plan, ever.

LEGAL SERVICES PLAN

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"(The assistance of counsel) is one of the safeguards of the Sixth Amendment deemed necessary to ensure 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

LEGAL SERVICES BENEFITS

WHO IS ELIGIBLE?

If you are eligible for Faculty Association of Suffolk Community College Benefit Fund benefits, either as a full-time member of the Faculty Association or the Guild of Administrative Officers, or you are a retiree who has enrolled in and paid for the Enhanced Plus Plan, you are eligible for legal services benefits.

Your dependents are not eligible for legal services benefits unless specifically included in the benefit description.

GENERAL RULES REGARDING COVERAGE

Enrollment: To receive benefits, you must have completed a FA Benefit Fund Enrollment Card. The Enrollment Card provides the Fund with 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.

All correspondence addressed to the Fund must contain the member's name and address. Please notify the Fund office, in writing, of any changes of name, address, etc. Maintenance of current records assures efficient processing of your claim and prompt receipt of your benefits.

Appeals to the Board of Trustees: The Board of Trustees of the FA Benefit Fund adopts rules and regulations for the payment of benefits and all provisions in this booklet are subject to such rules and regulations and to the Agreement and Declaration of Trust, which established the Fund and governs its actions.

A covered member may request a review of action taken by the Fund office by submitting an appeal, in writing, to the Board of Trustees of Faculty Association of Suffolk Community College Benefit Fund, 533 College Road, Southampton Building, Room 224D, Selden, New York 11784.

HOW TO USE THE LEGAL SERVICES PLAN

If you wish to make an appointment to consult a lawyer for benefits provided, call 631-732-6500.

You will be provided with an attorney from a panel law firm selected by the Fund. This firm will provide you with the benefits of the Fund. 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 employee of the Fund or any Trustee of the Fund can interfere in this relationship.

The Fund is designed to help pay for covered legal services. While the Fund cannot pay for all legal costs you have, 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. 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 required to make the appropriate payment as indicated in the plan of benefits.

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 to make payment to such attorney for services. However, the Fund will not absorb nor be responsible for any part of the fees or charges of attorneys other than those on the panel for the legal services program. You are also free at any time to discontinue the services of the panel law firm, and if you desire, 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 non panel attorneys. In addition, you continue to be obligated to the panel law firm for any cost 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, you are free to secure your own counsel. However, the Fund will neither absorb nor be responsible for any of the fees or charges of a non panel attorney.

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*.

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 is sued jointly with another defendant, including a spouse/domestic partner, the non-member/co-defendant 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.

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

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, Orange, 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 Fund 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 seeks a separation from his/her spouse by means of a separation agreement mutually agreed upon by the parties or any relief though the court by an action for an uncontested legal separation.

What is the Benefit? The Fund provides coverage through a panel law firm for all necessary legal services which the preparation and negotiation of a separation agreement may require. The separation agreement may be prepared and executed with a minimum of consultation or it may necessitate extensive negotiation 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 the Panel Law Firm	**Amount Paid by Fund Member**
A.	Consultation	None
B.	Uncontested or cooperatively agreed separation with minimal negotiation	$45
C.	Settlement after extensive negotiation	$75

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 you in each circumstance:

	Steps in the Legal Process Provided by The Fund through the Panel Law Firm	**Amount Paid by Fund Member**
A.	Consultation	None
B.	Litigation: including, for example, conference, preparation of Summons and Verified Complaint, documents relating to maintenance and support of children (inproper instances), Findings of Fact and Conclusions of Law.	$180

How to Obtain the Benefit? To obtain the Uncontested Legal Separation Benefit, simply contact the Fund 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 Fund provides coverage for all steps of the legal process in the category of uncontested divorce proceedings.

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 the Panel Law Firm

A. The member is entitled to ten hours of legal representation, 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 under this benefit when:

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

Amount Paid by Fund Member $60.00

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.

Amount Paid by Fund Member HOURLY

The panel law firm has agreed to provide said representation under B. with a 25% reduction in its hourly rate, which hourly rate has been established as $350.00 for calendar year 2015.

How to Obtain the Benefit? To obtain the Uncontested Divorce Proceedings Benefit, simply contact the Fund 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 ANNULMENT PROCEEDING BENEFIT

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

What is the Benefit? Annulment proceedings may be categorized as uncontested or contested. The Fund provides coverage for all steps of the legal process in the category of uncontested annulment proceedings.

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 the Panel Law Firm	**Amount Paid by Fund Member**
A.	Consultation	None
B.	Uncontested Annulment - Coverage includes, for example, Summons and Complaint, Note of Issue, preparation of Findings of Fact, Conclusions of Law, entry of Judgment	$60

How to Obtain the Benefit? To obtain the Uncontested Annulment Proceeding Benefit, simply contact the Fund 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.

What is the Benefit? The Fund will provide a covered member with an attorney from a panel law firm to represent the member 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 the member in each circumstance:

	Steps in the Legal Process Provided by The Fund through the Panel Law Firm	Amount Paid by Fund Member
A.	Consultation	None
B.	Preparation of Documents and Court Appearance for adoption of child	$65

How to Obtain the Benefit? To obtain the Adoption Benefit, simply contact the Fund 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 Eligible? Any covered member is entitled to this benefit.

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. All bankruptcy matters require attendance at at least one (1) creditor's meeting.

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 the Panel Law Firm	Amount Paid by Fund Member
A.	Consultation	None
B.	Simple Personal Bankruptcy	$75
C.	Complex Personal Bankruptcy	$100

How to Obtain the Benefit? To obtain the Personal Bankruptcy Benefit, simply contact the Fund 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 Eligible? Any covered member is entitled to this benefit.

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 the member in the change of name process.

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	None
B.	Actual change of name procedure	$45

How to Obtain the Benefit? To obtain the Personal Bankruptcy Benefit, simply contact the Fund 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'S RIGHTS BENEFIT

Who is Eligible? Any covered member who is purchasing 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.

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 of unimproved property with the intention of building a home in which the member expects to primarily reside or the refinancing of a mortgage on a primary residence. The legal services plan does not provide representation in any phrase 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 the Panel Law Firm	Amount Paid by Fund Member
A.	Consultation	None
B.	Negotiation, advice and representation in the sale, purchase or refinance of a primary residence	$60.00

It should be noted that this benefit does not include any aspects of residential problems that involve Title searches or Title insurance or the costs of same.

The second component of the Homeowner Rights Benefits 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 the Panel Law Firm	**Amount Paid by Fund Member**
A.	Consultation	None
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 Fund 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 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 to the members in those instances where the member's 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 CONSULATION BENEFIT (Three Each Year)

Who is Eligible? All covered members are entitled to this benefit.

What is the Benefit? This benefit provides covered members with an opportunity to consult with an attorney from the panel law firm for three one-half hour sessions each calendar year concerning any legal questions whatsoever*. This benefit is made available by the Fund at no charge to a covered member.

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

*The General Consultation Benefit does not include representation. If such representation involves a covered member, 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 the member.

DOCUMENT REVIEW BENEFIT*

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

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 Return

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 Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

*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.

WILL BENEFIT

Who is Eligible? Any covered member and his/her spouse, if agreeable to the member, are entitled to this benefit. In addition, the parent(s) and 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? This benefit provides for the preparation and execution of a will, with a simple testamentary trust if appropriate, for the member, his/her spouse (if agreeable to the member), the member's parent(s) and parent(s)-in-law under the supervision of an attorney from the panel law firm. The benefit is provided without charge, not more than once in every twelve month period.

How to Obtain the Benefit? To obtain the Will Benefit, simply contact the Fund to request an appointment. At the time of the appointment, the appropriate forms will be completed. A second appointment will be scheduled for the execution (signing) of the completed will(s).

PERSONAL INJURY (NEGLIGENCE) BENEFIT

Who is Eligible? A member and 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 Legal Services Program 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 Fund 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? Any covered member or dependent who is a defendant in a criminal proceeding in Nassau, Suffolk, Westchester, Putnam, Dutchess, Rockland or Orange Counties, or the five boroughs of New York City.

What is the Benefit? The benefit provides coverage through the panel law firm for necessary legal assistance by telephone consultation 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 the member/dependent is charged as the defendant in a criminal matter. It is important to note, however, that this benefit does not cover the costs of legal assistance beyond the arraignment telephone consultation stage. Thus, if the member/dependent is interested in obtaining legal services beyond the arraignment stage, he/she must make the necessary arrangements directly with the panel law firm or retain another attorney of his/her 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 the Panel Law Firm	**Amount Paid Fund Member**
Consultation	None

How to Obtain the Benefit? To obtain the Arraignment Assistance - Telephone Consultation Benefit, the member should contact the panel law firm so that the appropriate arrangements may be made.

This service is available at any hour of the day or night by calling the panel law firm at 516-466-6030.

CONSUMER PROTECTION BENEFIT

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

What is the Benefit? This benefit provides members 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*.

***NOTE:** Some legal services not provided under this benefit include, but are not limited to, suits for Punitive Damages, Class Actions and Commercial Enterprises.

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 the Panel Law Firm	Amount Paid by Fund Member
A.	Consultation	None
B.	Representation by Written Communication	None
C.	Litigation in Small Claims Court	$50
D.	Litigation in Courts other than Small Claims Court	$100*
E.	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., new/used car Lemon Law- then the cost to the member for Litigation or representation shall be $250.00.

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

IDENTITY THEFT PROTECTION BENEFIT

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

What is the Benefit? The Benefit 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 theft of personal information theft including but not limited to the following examples:

- using or opening of a credit 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 department of the appropriate creditors or financial institutions, the police and the Federal Trade Commission.

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

How is the Identity Theft Benefit Obtained?
To obtain the Identity Theft Benefit simply contact the Benefit Fund 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 commencing litigation other than that already provided in the Consumer Protection Benefit.

DON'T BE A VICTIM: STOP IDENTITY THIEVES COLD

THE PROBLEM
Identity thieves steal information, such as credit card, Social Security and driver's license numbers, then open accounts and run up charges in the consumer's name. Or, they fraudulently charge goods and services to a consumer's existing accounts. In other cases, they may work or be arrested while using a victim's name. The harm to a consumer's credit and daily life can be devastating. Victims often have trouble obtaining credit due to damaged credit ratings.

If you think you have become a victim of an identity or personal information theft, here are three steps you can immediately take:

1. Contact the fraud departments of each of the three major credit bureaus and report that your identity has been stolen. Ask that a "fraud alert" be placed on your file and that no new credit be granted without your approval.
    - Equifax: 1-800-525-6285
    - Experiean: 1-888-397-3742
    - Trans Union: 1-800-680-7289

2. For any accounts that have been fraudulently accessed or opened, contact the security department of the appropriate creditors or financial institutions. Close those accounts and put passwords (not your mother's maiden name) on any new accounts you open.

3. File a police report in the jurisdiction where the identity theft took place. Get a copy of the report in case you are requested to provide proof of the crime later.

The Federal Trade Commission ("FTC") assists victims of identity theft by providing them with information to help them resolve the financial and other problems that can result from identity theft. The FTC's Identity Theft Hotline is 1-877-ID-THEFT (438-4338).

PREVENTION

The following 14 steps will help you reduce your risk of identity theft.

1. Guard your Social Security number. It is the key to your credit report and banking accounts and is the prime target of criminals.

2. Monitor your credit report. It contains your Social Security number, present and prior employers, a listing of all account numbers, including those that have been closed and your overall credit score. After applying for a loan, credit card, rental or anything else that requires a credit report, request that your Social Security number on the application be truncated or completely obliterated and your original credit report be shredded before your eyes or returned to you once a decision has been made. A lender or rental manager needs to retain only your name and credit score to justify a decision.

3. Shred all old bank and credit statements, as well as "junk mail" credit-card offers, before trashing them. Use a crosscut shredder. Crosscut shredders cost more than regular shredders but are superior.

4. Remove your name from the marketing lists of three credit-reporting bureaus. This reduces the number of pre-approved credit offers you receive.

5. Add your name to the name-deletion lists of the Direct Marketing Association's Mail Preference Service and Telephone Preference Service used by banks and other marketers.

6. Do not carry extra credit cards or other important identity documents except when needed.

7. Place the contents of your wallet on a photocopy machine. Copy both sides of your license and credit cards so you have all the account numbers, expiration dates and phone numbers if your wallet or purse is stolen.

8. Do not mail bill payments and checks from home. They can be stolen from your mailbox and washed clean in chemicals. Take them to the post office.

9. Do not print your Social Security number on your checks.

10. Order your Social Security Earnings and Benefits statement once a year to check for fraud.

11. Examine the charges on your credit-card statements before paying them.

12. Cancel unused credit-card accounts.

13. Never give your credit-card number or personal information over the phone unless you have initiated the call and trust that business.

14. Subscribe to a credit-report monitoring service that will notify you whenever someone applies for credit in your name.

Although it's impossible to guarantee that your personal information will not get stolen, by following the above listed tips you can greatly reduce the risk.

LEGAL PLAN ASSISTANCE

Of course, please feel free to utilize the Faculty Association of Suffolk Community College Benefit Fund Legal Services Plan of benefits which provides the following, all applicable to "identity theft" issues:

General Consultation Benefit - provides coverage through the panel law firm for a member to consult with an attorney concerning any legal questions whatsoever.

Document Review Benefit - provides coverage through the panel law firm for professional review and interpretation of all legal documents, such as: guarantees, warranties, installment purchase agreements, loans, leases, insurance policies and court papers.

Consumer Protection Benefit - provides 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 fraudulent practices by merchants, department stores, home repair contractors, public utilities, automobile dealers, appliance dealers, etc.

LIVING WILL/HEALTH CARE PROXY BENEFIT

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

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

A living will serves as 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 health care proxy allows you to appoint someone you trust to make health care decisions for you if you lose the ability to make decisions yourself.

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

ESTATE PLANNING/TRUST 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 parent(s)-in-law.

What is the Benefit? The benefit provides covered members and their spouses/ domestic partners, parent(s) and 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 the Panel Law Firm	**Amount Paid by Fund Member**
A.	Consultation	$150.00 *
B.	Preparation and execution of the following special estate planning trusts at 20% off the usual and customary fee:	
•	**Irrevocable Life Insurance Trust ("ILIT")** - Designed to remove life insurance proceeds from the insured's and the surviving spouse's taxable estate.	20% Off the Usual and Customary Panel Law Firm's Fee**
•	**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 residence for a number of years, providing such term is less than the grantor's life expectancy.	

* To be credited to fee for preparation of trust.

** Usual and customary fee charged by the law firm is $3,250 per trust for all trusts except QRPT trusts, which is $3,700 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.

PLANNING FOR THE ELDERLY BENEFIT

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

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

How to Obtain the Benefit? To obtain the Planning for the Elderly Benefit, either you, your spouse or your domestic partner should contact the Fund to request an appointment. At the time of the appointment, you and an attorney from the panel law firm will complete the appropriate forms.

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 member's 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 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 the Panel Law Firm	Amount Paid by Fund Member
A.	Consultation	None
B.	Small Estate Proceedings	$150
C.	Estates other than Small Estate Proceedings	$250 plus*

* The panel law firm has agreed to provide legal representation in these matters with a 25% reduction in its hourly rate, which, for 2015 is $350.00 or $262.50 under the plan.

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

COUNSELING OF EMANCIPATED* CHILDREN BENEFIT

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 Fund to request an appointment for your child. At the time of the appointment, your child and an attorney from the panel law 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.**

GENERAL EXCLUSIONS FROM ALL BENEFITS OF THE LEGAL SERVICES PLAN

All legal services provided by the Fund have been specifically stated and described. Any legal service that has not been so described is excluded from the Plan of Benefits.

However, in order to guide the member in his/her utilization of the Legal Services Program 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 or filing of income tax returns or payment of income tax;

- 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 the member was previously represented by an attorney;

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

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

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

- The Fund will not cover non-members (e.g. spouses, parents, parents-in-law, etc.) on a first time basis or subsequent to coverage for a prior matter, without the express written consent of the member.

THE FUND WILL NOT PAY:

- For services or advice when such activity involves a duplication of the same service or advice previously obtained in connection with the same problem previously claimed for under the Plan;

- Court costs and/or filing fees, nor in any event will the Fund pay fines, penalties or any amounts in which a member may be cast in judgment.

IF YOU HAVE ANY QUESTIONS WITH REGARD TO COVERAGE, BENEFITS OR EXCLUSIONS, PLEASE CONTACT THE FUND OFFICE.